Te Whatu Ora
Health New Zealand

Regional Female Stress Urinary Incontinence Multidisciplinary Team Meeting (MDM) – Terms of Reference

1 Purpose & Brief

Purpose

The purpose of the Stress Urinary Incontinence Regional Multi-disciplinary Team Meeting (MDM Meeting) is to facilitate comprehensive multidisciplinary input into the treatment planning, ongoing management, and care of all women seeking treatment for Stress Urinary Incontinence (SUI), with a dedicated emphasis on ensuring safe and effective patient outcomes.

Aim

All discussions, outcome and agreements are predicated on the aim that they will ensure safe clinical care and enhance the patient's quality of life and experience of the health service.

Scope

In Scope	Out of Scope
• Patients referred to women's health or urology who are being considered for surgical treatment for SUI, this includes patients being considered for bulking agent insertion. ***Note:*** Any health practitioner involved in the treatment of a patient with SUI can present the case at MDM e.g., when non-surgical intervention is no longer providing the intended improvement, or it no longer supports the patient's goals of treatment.	• Consumers experiencing complications associated with mesh implanted for a SUI or POP who meet the Tier 3 surgeon criteria[1]. • Patients under the care of Spinal Care Units requiring SUI procedures.

[1] National Credentialling Framework: Pelvic floor reconstructive, urogynaecological and mesh revision and removal procedures | Ministry of Health NZ

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Objectives

The Chair and meeting participants will ensure that:

1. **Regular Multidisciplinary Discussion:** All female SUI cases presented to gynaecology, urogynaecology, and urology for invasive treatment are discussed regularly. The team will have access to all relevant information to make timely clinical recommendations.
2. **Evidence-Based Recommendations:** Treatment recommendations are based on evidence and aligned with the patient's treatment goals and clinical circumstances. When evidence is lacking, best practice recommendations and consensus expert opinions from credentialed practitioners are utilised.
3. **Professional Involvement:** Health providers directly involved in the patient's care participate in case discussions, ensuring interactions are respectful, appropriate, and professional. Providers not directly involved may be invited by the chair or presenter to join discussions and ask questions accordingly.
4. **Documentation and Communication:** Treatment recommendations are documented and communicated to relevant team members and external health providers, including the referring physician, primary health practitioner (if applicable), Accident Compensation Corporation (if applicable), and included in the patient's medical records

2 Governance

Governance Principles for the Meeting

- **Commitment to Excellence:** MDM quorum members are dedicated to excellence and fostering a culture of continuous improvement in all health planning and interactions.
- **Governance Framework:** Meeting processes, quality, and culture are integral to the clinical governance framework and are overseen by the Chairperson's district hospital Governance Committee.
- **Reporting Responsibilities:** MDM quorum members must provide biannual reports and statistics on meeting activities. The Chairperson is responsible for submitting these reports to their district hospital Chief Medical Officer and Clinical Governance Board.
- **Risk Management:** Chairpersons must discuss any risks associated with hosting a regional MDM with their Operations/Service Manager and, if necessary, record them in the hospital Risk Register.

3 Structure

Member Accountability

- **Collaboration with Coordinator:** The MDM Chair will work closely with the meeting coordinator to administer, deliver, document, review, and produce reports for each case presented
- **Ensuring Inclusivity:** The Chair will address any behaviour that undermines the creation of an inclusive team culture, where every voice is valued, immediately and professionally. If issues cannot be resolved during the meeting, they must be managed urgently outside the meeting, in accordance with Te Whatu Ora Human Resource Management policies. Repeated behaviour issues with the same member should be escalated to the Service Operations/Business Manager.

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- **Case Referrals and Communication:** All public and private health practitioners can refer and present cases to the MDM. The referring practitioner is responsible for informing the patient of the outcome.
- **Confidentiality:** The Chair will ensure that confidentiality is maintained at all times. Any breaches of confidentiality must be reported immediately to the Clinical Director and Operations Manager at the host site for appropriate management. The Chair or Deputy Chair is responsible for ensuring that outcomes from such escalations are addressed. All Health New Zealand |Te Whatu Ora healthcare professionals are bound by confidentiality agreements as part of their regular employment contracts.
- **Educational Component:** The MDM process does not set out to provide a formal structured education for participants. While indirect learning may occur through active participation, there is no assessment of learning to ensure comprehension. The Chair is responsible for managing situations where teaching is appropriate, balancing the meeting's time and flow, and making recommendations for follow-up outside the meeting to ensure effective learning outcomes.

Meeting Structure

<table>
<tr><td>Chair & Deputy Chair</td><td colspan="3">• Is credentialed at Tier 2 or 3 (according to the New Zealand Framework), with a minimum of 2 forms of SUI surgery and continues to meet the minimum volume criteria to maintain this status.
• Deputy Chair will step up in the absence of Chair. The Deputy will need to meet the same criteria outlined above.</td></tr>
<tr><td>Quorum requirements</td><td colspan="3">1. To achieve a quorum of surgeons, the composition of members must cover the full range of Tier 2 procedures outlined in the NZ SUI Framework to ensure robust discussion of options on behalf of patient can occur.
2. The makeup of surgical disciplines from point 1 must include at least 1 surgeon from each discipline as listed below.
3. Quorum members may participate either in person or via a digital link. However, written submissions on the cases for discussion are not acceptable for meeting quorum requirement
4. Requests to present by proxy will not be supported. It is acknowledged that there may be exceptional circumstances e.g., time sensitive decision will adversely impact the patient. Request to use a proxy require discussion and agreement by the MDM Chair or Deputy Chair in their absence and are considered an exception for extraordinary circumstances.</td></tr>
<tr><td rowspan="2">Attendance</td><td>Quorum</td><td>Members invited to every meeting</td><td>Invited as required</td></tr>
<tr><td>• MDM Chair or Deputy Chair
• Gynaecologist/urogynaecologist
• Urologist
• Pelvic Health Physiotherapist
• Continence nurse</td><td>• Motility CNS
• Colorectal surgeon
• RMO
• Fellows</td><td>• Radiologist</td></tr>
<tr><td></td><td colspan="3"><u>Note:</u>
• Guest invitations extended by a listed member must be approved by the MDM Chair prior to attendance.</td></tr>
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- If approval is granted, the member who invited the guest is responsible for ensuring that the guest is informed of this Terms of Reference (ToR) and the confidentiality agreement. Guests can include trainees in any health discipline.

Essential: Guest attendance details must be captured in the MDM records.

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<tr><td>Attendance records</td><td>Meeting coordinator will record attendance (partial or full meeting) at every meeting.</td></tr>
<tr><td>Frequency</td><td>

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<tr><td>Frequency</td><td>

- Monthly for smaller population groups
- Fortnightly for larger population groups

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<tr><td>Meeting duration</td><td>

- 1 hour for smaller population groups
- Up to 90 minutes for larger population groups

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<tr><td>Venue</td><td>

- To be sourced and secured by the Chairpersons or a member of their team at the host hospital.
- Secure digital room meeting link (Teams) for all attendees

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<tr><td>Virtual capability</td><td>

- Each member is responsible for ensuring they have digital link capability and appropriate display to sufficiently view shared images e.g., UDS tracing, radiology images.
- Host centre to ensure they have suitable size screen to see all attendees and view any images e.g. UDS tracings with sufficient clarity to support decision making.

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- All meetings will be video linked and recorded.
- Management of recordings is in accordance with the host hospital site.
- Access to recordings is restricted to the meeting Coordinator, MDM Chair and the Deputy Chair. See monitoring and reporting section for request to access MDM recordings.

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<tr><td>Minutes & Agenda</td><td>

- The schedule of dates will be published yearly.
- Referrals to MDM for discussion are to be received by the meeting coordinator no later than 72 hours prior to the meeting.
- Publication of cases for discussion will be distributed no later than 48 hours prior to meeting.
- Requests to remove a case from presentation should be received no later than 24 hours before the meeting.
- Discussion and outcomes will be captured, wherever possible, in real time by the meeting coordinator. Where this is not possible, outcomes will be checked by the meeting coordinator and CNS for approval by MDM Chair.

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Minimum Data Set	• MDM Referral form contains the minimum data required to present a patient at an MDM. This data set ensures evidenced based safe decision making can occur. • Presenting practitioners may add additional relevant items.
Monitoring and reporting	The success of the MDM will be measured and reported with the following: • Bi-annual (twice a year) report of the following to be sent to MDM membership group and CMO of the Chairperson's host hospital: ❖ Number of cases referred by ethnicity. ❖ Number of cases discussed by ethnicity. ❖ Number of cases deferred by ethnicity. ❖ Outcome recommendation, by category and ethnicity ❖ Number of cases where surgery is recommended by ethnicity. ❖ Service origin of cases discussed by ethnicity and domicile locality. ❖ Number of meetings. ❖ Percentage of quorate meetings. ❖ Number of attendees, by designation. • Requests to utilise MDM data (including recordings) must follow local district hospital and regional ethics requirements for the host site. • A courtesy notification to the Chair is required to ensure no conflict with pending reports or publications is known. • MDM member satisfaction survey (at 6 months from onset, annually thereafter).

Appointment & Terms

- MDM Chair will be reviewed every two-years, with nominations and ratification by quorum members.
- The ToR review is led by the Regional MDM Chair representatives. The ToR review period is three yearly or ad-hoc if at least 1 of the following criteria is met:
  - ❖ An agreed/proposed change in national operational guideline
  - ❖ Nationally proposed change to governance process.
  - ❖ Chair or significant number of members across the regions propose a review.
- Ratification of the ToR is carried out by the Regional MDM Chairs and the NZFPMS MDM Chair.
- Records of review and ratification process, with signatures of members to be kept by meeting coordinator in accordance with district hospital-controlled document process.
- These ToR are to be held at each participating district hospital in accordance with their controlled document process.

3.1 Member Requirements

- Deputy Chair will lead the meeting in the absence of the Chair. A meeting cannot progress without either the designated Chair or Deputy Chair.
- Cancellation of meetings is not recommended, all reasonable steps to ensure continuity with a Chair and the required quorum is the responsibility of the Chair. In the event a cancellation is not preventable, the intended notice period is 24 hours.

- Apologies from Quorum Members are to be communicated to the meeting coordinator no less than 48 hours prior to the meeting.
- Request to defer presentation of a case by the presenter are to be forwarded to the Chair and meeting coordinator 72 hours prior to meeting.
- Late additions will be forwarded to the Chair for consideration up to 48 hours before the meeting, if agreed, the meeting coordinator will advise the quorum and relevant 'as required' invites. No cases will be added after this time.
- If a patient presents acutely and an expert panel discussion to agree acute treatment is deemed appropriate, the patients lead physician will email the Chair and meeting coordinator to request an urgent quorum of 3 Senior Medical Officers (from the quorum list) to discuss the case and agree treatment. Decision to represent the patient retrospectively at the next MDM meeting sits with the chair. The patients name surgeon is responsible for entering documentation into the patients clinical records of an out-of-MDM discussion, noting who was involved, discussion points and agreement.

3.2 Decision Making / Escalation

Agreement to make a recommendation or action requires the following agreement process:

- Non-surgical agreement – a majority of quorum attendees is required (i.e., ≥51%). In the event of a split decision, the meeting Chair will have the casting vote.
- Surgical recommendation: the "consensus-minus-one" rule shall apply, i.e. all credentialled surgeons present at the meeting must agree, with the exception that one dissenting voice is permitted. Dissent is to be recorded in the minutes.
    - ❖ In the event that only two credentialled surgeons are present at the meeting, the dissenting voice rule will not apply.
    - ❖ When only two credentialled surgeons are present, if a unanimous agreement cannot be reached, a treatment decision will not be made, and as per the High Vigilance option the case will be referred to the NZFPMS MDM for presentation.
- In the event consensus cannot be reached, a decision will be deferred, and a referral shall be made to the NZFPMS National Co-leads for guidance outside of the meeting.

If parties feel aggrieved with the outcome, this will be discussed by relevant parties separate to the MDM and if indicated to be escalated according to the following pathway. This process needs to be treated as urgent and resolved within in 5 working days to prevent unnecessary impact on the patient treatment journey and the culture of the MDM.

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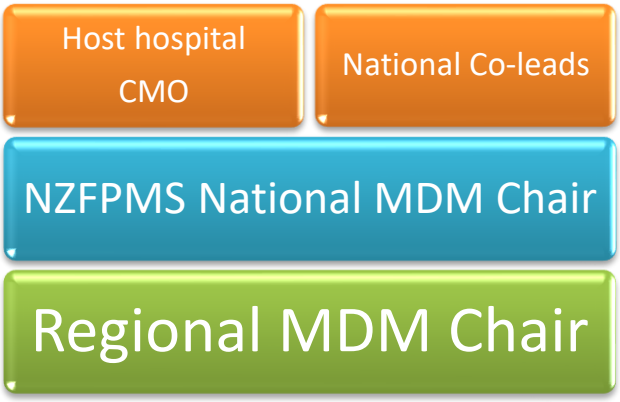
Figure 1 - Escalation Pathway



3.3 Additional Membership

Representatives from other disciplines may be invited on case-by-case bases and jointly determined by the Chair and case presenter.

Where an invitee is not a contracted member of the team, the final decision rests with the Chair on admittance to the meeting, sharing of any records and process to ensure Health New Zealand |Te Whatu Ora confidentiality requirements are understood and adhered to.