

Heart failure multidisciplinary meetings: joint British Society consensus guidelines for structure and function

A Joint Report from the British Society for Heart Failure, the British Association for Cardiovascular Prevention and Rehabilitation, the British Heart Rhythm Society, the British Society of Cardiovascular Magnetic Resonance, the British Society of Echocardiography, the British Geriatrics Society, the Primary Care Cardiovascular Society, and the British Cardiovascular Society

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1.0 Introduction

Heart failure is a highly prevalent condition that may result in limiting symptoms and shortened life expectancy. Both symptoms and prognosis of heart failure (with reduced ejection fraction) are improved by medical therapy: ‘the four pillars of heart failure’ (1). Newer agents, together with cardiac resynchronisation therapy (CRT), and evidence for the selected use of arrhythmia ablation and percutaneous mitral valve repair, have added treatment options for heart failure patients but they have also increased the complexity of clinical decision-making in this group.

Many heart failure patients can be managed according to standard treatment algorithms (2,3). Multidisciplinary meetings (MDMs), however, comprise an important part of the clinical pathway for more complex heart failure patients. The principles for the organisation of MDMs at the interface of cardiology and cardiac surgery are detailed in the document, ‘Making the most of the heart team: guidance for the structure and function of cardiac multidisciplinary meetings’, which was published in May 2021 (4). MDMs focused on the management of patients with heart failure were outside the scope of this document. Nevertheless, many of the principles described are generic and applicable to heart failure MDMs. This new document aims to define those principles which are specific to the structure and function of MDMs which consider the management of patients who have heart failure.

2.0 The role of the multidisciplinary meeting coordinator

All MDMs require a dedicated coordinator. This is a key role for the effective functioning of the meeting. The provision of cover for planned or unplanned leave requires two or more responsible individuals, who could be designated the lead and deputy coordinator, respectively. The responsibilities of the coordinator include:

- ensuring that completed referral forms and all investigation results are available for the MDM
- agreeing when specific patients will be discussed with the referring teams
- agreeing, in conjunction with the chair, a record of the MDM discussions
- ensuring that MDM outcomes are conveyed to referring teams in a timely fashion
- ensuring that MDM outcomes are enacted, for example, that referrals to other clinical teams such as the electrophysiology team, are made or liaising with the interhospital transfer coordinator to facilitate inpatient transfer, when necessary.

2.1 The role of the multidisciplinary meeting chair

The MDM chair is the second critically important role for the effective functioning of the meeting and for the MDT pathway as a whole. As such, the chair of the MDM must be an experienced clinician who has expertise in heart failure. Furthermore, the role should be recognised in job plans and included in formal appraisal discussions.

The chair is responsible for determining if the MDM is quorate. He/she is responsible for ensuring that all views are heard in a constructive dialogue which facilitates decision-making by consensus. The chair is responsible for ensuring that decisions are recorded accurately and impartially. The MDM summary should include sufficient detail of the discussion to allow the decision-making process to be reconstructed; unresolved differences of opinion should be recorded. If no consensus was reached, this should be stated. This is particularly important for complex cases and when differences of opinion were expressed. The chair should review the MDM outcome records during or after the meeting before they are signed off.

The chair, in conjunction with the MDM coordinator, is responsible for ensuring that the decisions made in the MDM and the resulting MDM records are formally communicated back to referring teams in a timely fashion. Communications should be electronic and should be entered into the medical records. In cases in which there is a transfer of care between teams, or between clinicians within a team, the chair should ensure that a named clinician is responsible for the ongoing management of each patient.

3.0 The multidisciplinary meeting process

The clinician responsible for the care of the patient should always be present at the MDM. A minimum dataset must be completed for all patients who are referred to the MDM. Meaningful discussion cannot be undertaken without these data and the question being asked of the MDM should be clearly articulated. Referrals should be made by a standardised electronic form which facilitates real-time tracking of patients' clinical journeys and audit of timelines and MDM outcomes. The rapid evolution of virtual technology has facilitated network involvement in the MDM and potentially also allows the involvement of patients and relatives in the discussion, either 'live' or in the form of a recording of a video consultation.

4.0 The heart failure pathway

All cardiac networks should have formal pathways for the management of patients with heart failure. These pathways should address diagnosis, medical treatment, complex device therapy, rehabilitation, and end-of-life planning (2). Primary and secondary care services should be included within a single governance structure which lends itself to integrated care. Highly specialised treatments, such as left ventricular assist devices (LVADs) and cardiac transplantation, which are not provided within every region, should be included in pathways which facilitate referrals between networks.

There are several points on the heart failure pathway where MDM discussion may be required for some patients, and it is likely that within most networks there will be a number of MDMs required. These could include the discussion of more complex patients in secondary care, patients being considered for complex device implants, those managed within the community in whom treatment is not straightforward, and those being considered for advanced therapies. These are not necessarily all mutually exclusive and within individual institutions and individual networks several functions could be covered by a single MDM. Many heart failure cardiologists have expertise in cardiac imaging or devices and will be able to fulfil more than one role in the MDM. It is also important to recognise the time constraints faced by busy clinicians and while a heart failure MDM may require the presence of a number of heart failure clinicians a single representative of other disciplines will generally be appropriate. The key requirement for all MDMs is that attendees have the collective knowledge and skills required to evaluate a particular patient and identify the optimum course of management.

4.1 Secondary care heart failure multidisciplinary meetings

All hospitals treating heart failure patients should have a regular, at least weekly, MDM to discuss both inpatients and outpatients. This could be combined with either a joint community heart failure MDM or a heart failure/devices MDM, depending on local circumstances.

4.1.1 Patients for discussion

- Patients who are failing to respond to therapy
- Patients whose clinical condition is deteriorating
- Complex patients who require transfer of care from primary to secondary care (and vice versa)
- Patients for consideration of escalation to more complex therapies
- Patients who require end-of-life decisions and/or palliative care
- Patients who are being considered for non-cardiac interventions

4.1.2 Minimum dataset

- Diagnosis
- Current clinical state and New York Heart Association (NYHA) functional class
- Comorbidities and frailty status (Clinical Frailty Scale if over 65 years of age)
- Social and functional history
- Current and previous drugs
- Relevant recent blood test results
- Recent 12-lead electrocardiogram (ECG)
- Relevant cardiac imaging results

4.1.3 Core attendees

- MDM coordinator
- Secondary care heart failure lead consultant
- Secondary care heart failure consultant
- Secondary care heart failure specialist nurse

4.1.4 Additional attendees (this list is not intended to be exhaustive)

- Care of the elderly/complex medical care consultant
- Palliative care clinician
- Renal medicine consultant
- Imaging cardiologist
- Occupational therapist
- Physiotherapist
- Dietician
- Cardiac physiologist/echocardiographer
- Pharmacist
- General practitioner with special interest (GPSI) in heart failure
- Cardiac surgeon
- Trainees in all disciplines

4.2 Joint community/secondary care multidisciplinary meetings

Most heart failure patients managed in the community can be treated according to agreed network protocols following National Institute for Health and Care Excellence guidance (ref). Secondary care services should provide a point of contact five days per week which allows primary care clinicians to refer patients back to secondary care and for patients on patient-initiated follow-up to reconnect with secondary care services.

There should be a mechanism within each cardiac network for MDM review of patients who are failing to respond to treatment or who are otherwise complex. This MDM should occur at least monthly. It should include clinicians from community and secondary care. The MDM should have access to both primary and secondary care clinical records.

4.2.1 Patients for discussion

- Patients who are failing to respond to therapy
- Patients with uncertain diagnosis/aetiology
- Patients whose clinical condition is deteriorating
- Complex patients who require transfer of care from primary to secondary care (and vice versa)
- Patients for consideration of escalation to more complex therapies
- Patients who require end-of-life decisions and/or palliative care
- Patients who are being considered for non-cardiac interventions

4.2.2 Minimum dataset

- Diagnosis
- Current clinical state and NYHA functional class
- Comorbidities and frailty status (Clinical Frailty Scale if over 65 years of age)
- Social and functional history
- Current and previous drugs
- Relevant recent blood test results
- Recent 12-lead ECG
- Relevant cardiac imaging results

4.2.3 Core attendees

- MDM coordinator
- Secondary care heart failure lead clinician
- Secondary care heart failure specialist nurse
- Community heart failure specialist nurse

4.2.4 Additional attendees (this list is not intended to be exhaustive)

- Secondary care heart failure consultants
- Care of the elderly/complex medical care consultants
- Palliative care clinicians
- Renal medicine consultant
- Imaging cardiologist
- Cardiac rehabilitation
- Occupational therapists
- Physiotherapists
- Dieticians
- Cardiac physiologist/echocardiographer
- Pharmacist
- GPSI in heart failure
- Trainees in all disciplines

4.3 Joint heart failure/device/arrhythmia multidisciplinary meetings

All patients being considered for complex device implantation should be reviewed by at least one clinician with the expertise to determine the appropriateness of device implantation. This should include a heart failure consultant, who may also be a device implanter. In situations where the indication is clear and aligns with current guidance, these patients do not necessarily need to be reviewed formally in an MDM, but many services will choose to review all patients. Patients in whom the indication or benefit is unclear should be reviewed in a formal MDM. This MDM could also provide a forum for the discussion of patients for potential electrophysiological ablation.

4.3.1 Patients for discussion

- Patients with bradycardia devices who are approaching the need for a box change who may benefit from complex device implantation
- Patients who are being considered for new implants when the decision is not straightforward
- Patients who may benefit from conversion from bradycardia pacing
- Patients who require end-of-life decisions and device deactivation
- Patients where therapeutic arrhythmia ablation is a potential option

4.3.2 Minimum dataset

- Diagnosis
- Current clinical state and NYHA functional class
- Comorbidities and frailty status (Clinical Frailty Scale if over 65 years of age)
- Social and functional history
- Current and previous drugs
- Relevant recent blood test results
- Recent 12-lead ECG and any ambulatory ECG recordings
- Relevant cardiac imaging results

4.3.3 Core attendees

- MDM coordinator
- Heart failure cardiologist
- Device implanting cardiologist
- Heart failure specialist nurse
- Arrhythmia specialist nurse
- Cardiac physiologist with device expertise

4.3.4 Additional attendees (this list is not intended to be exhaustive)

- Community heart failure nurse
- Electrophysiologist
- Palliative care physician
- Imaging cardiologist
- Cardiac physiologist with echo expertise
- Cardiology trainees in heart failure/devices/imaging

4.4 Attendance of heart failure specialists at surgical/interventional multidisciplinary meetings

Input from heart failure specialists is required in other MDMs, particularly those which consider surgical or interventional management of secondary mitral regurgitation. It may also be needed when considering selected patients for myocardial revascularisation or for aortic or tricuspid valve interventions. All units performing these interventions should have a formal mechanism for obtaining specialist heart failure advice as required.

4.5 Advanced heart failure management

All networks should have a formal pathway for the referral of potential candidates for advanced heart failure management (left ventricular assist device implantation and cardiac transplantation) to specialist centres which provide these services.

References.

1. 2021 ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure. McDonagh TA, Metra M, Adamo M, Gardner RS, et al. European Heart Journal 2021;42(36):3599–3726
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3. [Management of chronic heart failure \(sign.ac.uk\)](#)
4. www.britishcardiosvascularsociety.org/_data/assets/pdf_file/0023/32657/MDM-Guidance-Final-Confirmed-for-Publication-May-2021.pdf