INTERNAL VALIDATION REPORT

(MULTI-DISCIPLINARY TEAM)

Network	EMSCN	
Trust	UNIVERSITY HOSPITALS OF LEICESTER	
MDT	Leicester Royal Infirmary HPB MDT (13-2N-1) - 2013/14	
Date Self Assessment Completed	31st March 2014	
Date of IV Review	24th February 2014	
Lead Clinician	Mr Giuseppe Garcea	
Compliance		
HPB MDT	**Self Assessment** 94.4% (17/18)	**Internal Validation** 88.9% (16/18)
Key Themes		
Structure and function of the service		

Self Assessment Comments

All key members of the MDT are in place with suitable cross-cover. With the exception of Palliative Care, the cover arrangements include consultant replacements. For palliative care, an ST6 (or above) trainee cover is in place. All members have completed their advanced communications courses. This is no longer a required measure; however, given that it continued to be for many years prior to 2013 continued compliance with this measure seemed appropriate. Since the last annual report a new oncologist has been appointed which has improved oncology cover for MDT meetings and improved access to neoadjuvant, adjuvant and palliative chemotherapy services. The HPB specialist MDT has three HPB Nurse Specialists / Key workers who are committed to patient care and support the patients from diagnosis through to treatment and post-treatment. Each scheduled MDT planning meeting a cover of 95% has been achieved with individual attendance at their scheduled MDTs of greater than 2/3.

The MDT meets weekly on a Monday at 14:00hrs and its aim is to rapidly diagnose, obtain histological confirmation of cancers (where appropriate) and treat referrals. Given the number of patients discussed at the MDT (between 50 to 60; with a peak of 80); the MDT works extremely well. However, it does struggle with the workload placed on the MDT co-ordinators (particularly from the number of out of area referrals generated from KGH, PBH and NGH). The implementation of the new Infoflex database may help in this workload as some of the typical data fields required for entering patients are automatically populated from the HISS database currently employed by the UHL. The HPB unit presently discusses over 1500r referrals per year with over 1,000 confirmed cancers.

Although relatively few HPB malignancies are suitable for resection; due to the large volume of patients discussed, the unit manages to retain major resection rate commensurate with other major HPB centres. The majority of patients present in their 70s to 80s which presents particular challenges in the work-up and selection of which patients are suitable for resection (which tend to be major operations with significant morbidity and mortality) For this reason, an HDU/HPB anaesthetist frequently attends the MDT to provide valuable anaesthetic support when discussing patients. Other than for primary liver cancers; ratios of male to female patients are approximately equal.

In keeping with Leicesters rich cultural diversity; up to 10% of pancreatic cancers treated and 10% of primary liver cancers are from an Asian background. This also creates challenges to the team who have to be aware of the cultural differences and

language barriers, which may impede effective communication and care delivery. In order to ensure complete equality and

access to treatment regardless of ethnicity and possible language barrier, the speciality MDT recently undertook a review of survival in patients of Asian origin with pancreatic cancer. No significant impediment in survival was found, in fact The breaches for the HPB diagnosed and treated cancers based on a diagnosis of ICD0 C22 to C25.9 for the period April 2011 to March 2012 are as follows:

62 day (Urgent GP Referral to Treatment)
Achieved: 28.5
Breached: 3.0
Total: 28.5 Percentage achievement 89.5% (Target 85%)

31 day (Diagnosis to Treatment)
Achieved: 97
Breached: 0
Total: 97 Percentage achievement 100.0% (Target 96%)

The specialist MDT has invested a significant degree of effort in improving its target cancer delivery times. An analysis of the 2WW referrals demonstrated that approximately 70% of referrals were generated from abnormal imaging (typically an USS) requested by the patients General Practitioner Most patients were initially seen in clinic to determine further investigations (which in almost all cases consisted of cross-sectional imaging). Typically most patients breached or failed to meet their targets in the 31-day part of their cancer pathway.

This data has been used to undertake a radical overhaul of the HPB 62-Day pathway. All patients are referred by GPs now go straight to imaging prior MDT discussion and clinic review. In addition all imaging which are electronically for MDT discussion are now intercepted by the MDT co-ordinators and appropriate imaging organised directly from the HPB office. The patients GP is communicated to via a faxed proforma to inform them of the outcome. Furthermore, a revised timeline for 62-day HPB referrals has been formulated and the cancer tracker gives the MDT Lead a list of patients who are not progressing appropriately along this pathway. Since its introduction in April 2013 a dramatic reduction in the number of breaches has been noted. The breaches which have occurred since April, all began their pathway prior to the implemented changes, it is expected that the following 12 months should see a further reduction.

Internal Validation Comments

Coordination of care/patient pathways

Self Assessment Comments

There are defined referral pathways which have been agreed at Network level. There are also specific diagnostic, treatment and follow-up guidelines on the management of HPB cancers agreed at the network level. These have recently been reviewed and ratified at the NSSG meeting on the 15th January 2014. Please refer to the annual report of the East Midlands NSSG for details of service development, network attendance and meetings and results of the patient experience.

In an attempt to reduce inappropriate referrals of patients with an Upper GI malignancy to HPB surgeons; the 2 week wait proformas and been re-designed as a collaborative project between the Lead Clinician for the HPB MDT and the gastro-oesophageal surgeons. The new forms have been approved and disseminated to the GPs within Leicestershire. These forms are in their infancy, but should allow for a direct referral to the most appropriate tumour site and improve the early diagnosis and treatment of HPB cancers.

In addition an online referral form for the HPB MDT has been devised by in-patient referrals. This has dramatically improved the quality of information provided to the HPB MDT allowing for a more informed discussion of patients. It has also reduced the time spent on by MDT co-ordinators verbally receiving referrals and obtaining clinical details.

UPGRADE OF ERCP SERVICE
For many patients with end-stage HPB malignancies, jaundice is the main presenting complaint. For these patients effective biliary drainage will be the main determinant of survival and quality of life. All ERCP services within Leicester is now provided by at a single site at the Leicester General Hospital. In addition, beds are now ring-fenced for urgent jaundiced patients. This has allowed for rapid treatment of patients with jaundice. The service was centralised in March 2013. An audit of mortality and morbidity of ERCP is planned next year to determine if this centralisation of the service has improved quality. To cope with this increase in output 6 new duodenoscopes have been purchased and a capital bid has been entered for a further two.

A significant component of the ERCPs undertaken in Leicester constitute out of area referrals from Kettering, Peterborough and Northampton. A new inter-hospital MDT form has been devised which enables better stratification of patient risk (based on Early Warning Scores, blood tests and performance status). This form is then graded for priority by a senior clinician and the patient is assigned a dedicated ERCP slot prior to transfer. Stable patients can be transferred across the preceding day (or even the same day) of their allocated procedure slot. This has reduced the length of time that elderly patients spend away from their base hospital (which often causes significant problems for their elder spouses being able to visit them).

ENDOSCOPIC ULTRASOUND SERVICE
UHL now has EUS comprising of a linear EUS scope suitable for pancreatic biopsies and other HPB work. In addition a gastroenterologist has been appointment to undertake this service. The EUS service is presently being rolled out to all referral hospitals who are struggling with their local EUS service.

ENHANCED RECOVERY SERVICE
Since April 2013 an Enhanced Recovery protocol has been in place for all patients undergoing major liver and pancreatic resections. Specific paperwork for both clinical and nursing documentation has been developed as well as patient information leaflets explaining the enhanced recovery process and principles. The aim of enhanced recovery has to been to reduce the length of stay following major HPB resections. Since its introduction the length of stay for pancreatic resections has been reduced from 15 days to 10.5 days, for major liver resections LOS has been reduced from 10 days to 6 days and for laparoscopic liver resections from 6 days to 3 days. We have undertaken an audit of patient satisfaction with their surgery before implementing enhanced recovery and we will be completing the audit cycle post ERP to ensure that patients the service has not negatively impacted on the patient journey.

PATIENT INFORMATION, DISCHARGE SUMMARIES & TELEPHONE CONSULTATIONS
Patients are now copied into their letters generated from their clinic consultation. This offers them a permanent record of their diagnosis and treatment options. In addition, the Key Workers also provide patients with a Patient Information Prescription outlining their disease and treatment pathway. The operational pathway provides examples of letters to patients.

In order to improve communication to patients, carers and GPs; templates for the ICE discharge summaries have been devised for all patients following liver and pancreatic resections. The discharge templates give patients and GPs the required information regarding their surgery and simple post-operative instructions. Furthermore the CNS / Key Workers also contact all patients discharged after major cancer resections (or palliative procedures) to reassure them and discuss any potential problems which may be developing.

Internal Validation Comments

Patient experience

Self Assessment Comments

A patient satisfaction survey was completed and feedback delivered to the HPB MDT by our senior CNS. The results of the patient survey were very good overall with 90% of patients recommending the UHL HPB unit to a friend. Thirty per cent of patients described difficulty in accessing a dietitian post-operatively and hence specialist dietitian cover is now part of the work programme for 2014. Other areas which could be improved upon is information delivery regarding alternative therapeutic procedures and information regarding support groups, financial help and free prescriptions. These results have been disseminated to the MDT team and the work plan incorporates a plan to improve on this by providing an information booklet purely covering aspects of free prescriptions, financial advice and a list of local and national patient support groups. There are still some out-standing questionnaires and when all data has been collected, the results will be presented formally at an MDT.

Internal Validation Comments

Clinical outcomes/indicators

Self Assessment Comments

Our top five clinical priorities are:
To not just meet expected targets but to exceed them with respect to patient care, patient pathways and both short-term and long-term cancer outcomes

To expand the role and reach of the Specialist MDT to surrounding areas and provide a reliable, efficient and effective forum for the discussion of new and follow-up HPB cancer patients

To progress with our academic achievements by setting new standards in clinical research (including pilot drug trials and randomised controlled trials) and also in translational molecular research. The commitment of our clinical and laboratory research is in the early detection of HPB malignancies and in both surgical and drug treatment of established malignancies.

To continue with regular audit and systematic reviews of the current literature and to widely disseminate this information at both a local and national level, with the long-term objective of continually refining and improving the service.

To treat each patient presenting to our MDT as a unique individual and formulate a treatment package which takes into account all his or her needs. To strive to ensure that patients are given a written record of their treatment plan with appropriate advice on additional resources of support.

MAJOR RESECTION RATES & MORTALITY RATES WITHIN 30 DAYS OF TREATMENT
We are a high-volume non-transplant Hepato-Pancreato-Biliary unit undertaking around 80 to 100 liver resections annually and 50 pancreatic explorations. Our 30 day mortality for the last two years has been 2.0% and 0.6% for pancreatic and liver surgery respectively. Pancreatic and liver resection rates are 15.8% and 14.6% respectively, for colorectal liver metastases the resection rate is 26.8%. These outstanding figures are among the best in the country. Patients have confirmation of their malignancy in 73.2% of pancreatic referrals and 72.6% of liver referrals. The cancer outcomes of this unit compare favourably with national averages and in many areas exceed them (for example, mortality and resection rates).

LONG-TERM SURVIVAL FOLLOWING RESECTION OF LIVER & PANCREATIC MALIGNANCIES
Median survival following resection of pancreatic ductal adenocarcinoma are 30 months and 1, 3 and 5 survival rates are 79.3%, 45.4% and 36.3% respectively. Median survival after resection of colorectal liver metastases was 47.5 months, 1, 3 and 5 year survival rates are 85.6%, 52.0% and 35.3% respectively. Our total recruitment to clinical trials over the last 12 months has been outstanding with the UHL (including Northampton) recruiting 90 patients for clinical trials.

Internal Validation Comments

Good Practice

Good Practice/Significant Achievements

Self Assessment Comments

The HPB unit in Leicester has a strong academic record with excellent representation at both National and International meetings. We have a prospectively maintained database (which is maintained by a dedicated HPB data analyst: Sara Whatton) which allows for regular review and audit of our results. The unit has contributed recently to the AUGIS database with data from its pancreatic and liver resections. The Enhanced Recovery paperwork also has a section which specifically collects data for the database.

The HPB consultants maintain excellent links with referring consultants from loco-regional MDTs and attend these MDTs in person. This fosters strong links and in addition dealing with cancer-referrals, strong support for complex benign disease is also provided (such as acute pancreatitis).

The last year has shown a strong sustained effort by the unit to improve its service. Achievements for 2013 include significant achievements which have already been mentioned above:

Updating and revising the 62-day pathway and adopting a straight-to-imaging approach (in addition to intercepting abnormal imaging which has been â€œtaggedâ€• for HPB attention

Introduction of a new 2WW referral form which is specific for suspected HPB malignancies

Introduction of an online referral form for HPB suspected cancers

Centralising the ERCP service and improving the patient pathway to a dedicated ERCP slot

Implementing an EUS service, with inter-hospital referral form

Revising the old ERCP referral forms to a new, which enables better prioritisation of patients for ERCP

Capital bid for new intraoperative ultrasound machines and EUS probes for an on-site EUS service

Telephone consultation between the Key Workers and post-operative patients following major resection

Improving the written information for patients and GPs on discharge, by having a template which pre-populates the discharge letter with advice regarding post-operative care and recovery

Implementing an Enhanced Recovery Service with a successful reduction in length of stay

Contributing to the AUGIS database and improving the Enhanced Recovery Paperwork to allow prospective capture of intraoperative clinical data.

Implementing a new database allowing better tracking of patients and better data collection (Infoflex system).

OTHER SIGNFICANT CLINICAL ACHIEVMENTS
APPOINTMENT OF A NEW HEPATO-PANCREATO-BILIARY SURGEON
A new HPB consultant has recently been appointed. He is an essential addition for the busy service at the UHL. Mr Malde has undertaken numerous fellowships and this breadth of experience has been invaluable to further developing and strengthening the unit. The new surgeon has also recently undertaken post-graduate teaching for the SpRs in the region. He has an active interest in teaching and education. He will also be undertaking EUS at the LGH. If the recent capital bid is successful, this will allow on-site EUS to be undertaken.

APPOINTMENT OF A NEW EUS PRACTICIONER
An EUS practitioner has also been recently appointed as a gastroenterologist (with an interest in pancreatic disorders). He is a proficient endoscopist and has taken the lead role in the EUS service at the UHL. This has seen rapid expansion both locally and more recently, EUS has been offered to the surrounding catchment area of the UHL as a direct referral service. His input to the MDT is much welcomed as a core member.

CONTRIBUTION OF CNS TO THE ALL PARTY PARLIAMENTARY ENQUIRY ON PANCREATIC CANCER
One of our CNS was recently invited to attend and give oral evidence at the all party parliamentary enquiry on pancreatic cancer. She was also involved in the drafting of the new HPB peer review measures for 2013. Recommendations from this group include:

Better education of GPs in the early diagnosis of pancreatic cancer

A more streamlined referral pathway from primary to secondary care (see work programme)

An audit of pancreatic cancer emergency admissions is undertaken (see work programme)

Dietitian input into MDT and pancreatic cancer patients (see work programme)

Input regarding patient-centred care from the hospice sector

More Streamlined Pathway from Primary to Secondary Care
The UHL HPB MDT has already made attempts to improve the referral pathway by way of the revised 2WW forms. Further work is planned for a â€œone-stopâ€• out-patient service which will incorporate ultrasound and CT imaging for patients presenting with obstructive jaundice. Plans for this service will allow GPs to directly refer patients with obstructive jaundice to clinic (rather than arranging admission) where USS (and if appropriate) CT imaging will occur on the same day after assessment in clinic. Patients will then be allocated a dedicated ERCP (as an outpatient) for biliary tree decompression +/- biopsy or staging laparoscopy (see work programme).

GP Education to be rolled out over 2014
In addition, we have made contact with GPs in Leicester and over the next 12 months will be offering teaching sessions on risk factors for pancreatic cancer and its early diagnosis.

Input from the Hospice Centre Regarding Patient-Centred Care
For the last 12 months, the MDT chair and a CNS have been participating in representing HPB on the End of Life care initiative in Leicester (led by a consultant in palliative care), This has resulted in ward nurses have being trained in End of Life care.

Audit of Emergency Pancreatic Cancer Admissions
An audit is planned for 2014 to examine all emergency admissions with a new diagnosis of pancreatic cancer. The notes will then be retrospectively assessed to determine any factors which could have led to an earlier diagnosis. This information will

then be published in peer-reviewed journals and disseminated to GPs (see work programme).

Dietitian Input into Patients with Pancreatic Cancer
The MDT already has a dietitian as part of the extended MDT membership (and will probably be expected to be core members within the next five years). Attempts are being made to secure funding for a dedicated dietitian for HPB cancer patients. Weight loss secondary to cancer catabolism is a major cause of mortality in patients with palliative pancreatic cancer. In addition, it can severely affect quality of life. Nutritional advice will help performance status to be maintained in these patients which will enable life-prolonging chemotherapy treatment. Furthermore, adequate pre-operative optimisation of patients will prove invaluable for those on an enhanced recovery programme to expedite hospital discharge and minimise length of stay on critical care (see work programme).

NEW PERSONALISED MDT LISTS FOR RADIOLOGY AND PATHOLOGY
The MDT has been modified to generate three separate â€œnewâ€• and â€œreviewâ€• lists. This includes a list for the core members, a modified list for radiology and a separate list for pathology. This has resulted in supporting services, such as radiology and pathology, spending more time on their dedicated list of patients. This has led to better patient care with faster turnaround of histology results and more detailed review of imaging.

LEICESTER CHARITY BIKE RIDE
Clinicians, nurse specialists, MDT co-ordinators and members of the public recently organised an 80 mile charity bike ride from Leicester to Skegness. This has raised over Â£25,000 for research into pancreatic cancer. The ride was a huge success in terms of funding raised and also helped improve the local profile of the HPB unit. The bike ride has also improved strengthened relationships between the clinical unit and major stakeholders such as patients. The bike ride also gained significant local media coverage and raised the profile of pancreatic cancer.

TOTAL PANCREATECTOMY & ISLET BID
Chronic pancreatitis has a significant deleterious effect on patient quality of life due to chronic intractable pain. In addition, it confers a significant cumulative risk (1 to 2% per annum) for pancreatic cancer. One way of treating both pain and avoiding cancer risk is by operating to remove the pancreas and transplant the islet cells (hence avoiding the problem of having patients who are brittle diabetics post-operatively). Our lead senior surgeon is a world leader in this field and is currently securing funding to allow this valuable service to continue, in collaboration with only 3 other units in the UK.

RESEARCH AND PUBLICATIONS (INCLUDING MULTI-CENTRE FISH OIL TRIAL IN PATIENTS UNDERGOING LIVER RESECTION)
The UHL HPB MDT unit is internationally recognised as a centre of excellence for both clinical and translational research into cancer studies. The UHL research lead is involved in significant number of collaborative studies internationally and nationally. Recent note-worthy collaborations are a randomised controlled trial of fish oil in patients undergoing liver resection to be undertaken between Leicester, Leeds and Newcastle. In addition, the unit has seen 3 MD degrees awarded in the last year. A monthly research meeting is held where recruitment to clinical trials and interim bench research is discussed

Internal Validation Comments

Concerns

Further Immediate Risks Identified?

Not Identified

Immediate Risks

Self Assessment Comments

Internal Validation Comments

Further Immediate Risks Resolved?

Not Applicable

Immediate Risks Resolution

Self Assessment Comments

Internal Validation Comments

Further Serious Concerns Identified?

Not Identified

Serious Concerns

Self Assessment Comments

Internal Validation Comments

Further Serious Concerns Resolved?

Not Applicable

Serious Concerns Resolution

Self Assessment Comments

Internal Validation Comments

Concerns

Self Assessment Comments

Several concerns have been noted which may adversely affect the quality of the service of the HPB MDT.

The location of the EUS service off-site from the LGH has resulted in complex procedures such as pancreatic biopsies undertaken without on-site specialist consultant cover. Whilst there is surgical consultant cover at the LRI, they are not pancreatic specialists and hence are not fully equipped to cope with any complications which may occur. In addition, for in-patients undergoing EUS-guided biopsies this results in an unnecessary transfer to a different site which interrupts the patient pathway and inconveniences them. It is hoped that a successful capital bid will rectify this.

The intraoperative ultrasound (IOUS) is no longer fit for purpose and requires replacing. The replacement equipment bid, should correct this.

Surgical services in Leicester are undergoing a major re-structuring with plans to move all of surgery (including HPB) to the Leicester Royal Infirmary and/or an arbitrary split between emergency and elective work. This will have major implications on the workflow of the HPB unit prejudicing patient care and safety.

Presently, the Leicester Royal Infirmary as a site for HPB would result in reduced access to radiology, critical care beds, interventional radiology, endoscopy and ward beds. This would decimate the service making it impossible to move patients in for urgent ERCPs and to undertake major cancer resections.

Many up to 40% of HPB malignancies require emergency admission because of obstructive jaundice. This is often their first presentation. Splitting emergency care from the elective beds will result in a major disruption in the patient flows. It will create an unnecessary division and prevent the seamless pathway which at present involves decompression of patientâ€™s biliary tree followed by assessment for major resection.

Internal Validation Comments

General Comments

Self Assessment Comments

The specialist Hepato-Pancreato-Biliary MDT is an excellent well-coordinated team. All members work closely together with the sole aim of improving patient care. Leicester has worked hard to develop and maintain its reputation as a centre of excellence from both a clinical and academic perspective. We are keen to work closely with managerial staff to ensure that we have a strategic plan which will allow the unit to grow over the next 5 years.

Internal Validation Comments

Patient Notes reviewed:

The team are to be commended for the evidence supplied in relation to the Key worker guidelines. It was evident in the patientâ€™s notes that key worker documentation, including the Holistic Needs Assessment is used and therefore the MDT complies with these measures. The panel felt that it wasnâ€™t clear if a patientâ€™s Holistic Needs are taken into account in the decision making, the CNS assured that they attend the MDTâ€™s and play a vocal part. The Cancer Centre will explore adding a question to the InfoFlex audit tool, so that the MDT Co-ordinator can assure this for each patient.

Meeting with the MDT

The panel commended the MDT for all their hard work in producing the self assessments and evidence for Peer Review, as this is an excellent example of how it should be presented.

Measure 13-2N-101 level 2 Psychological Support for practitioners - non compliant. This is currently a non compliance across

the trust. The Cancer Centre is locating money to re-establish this support for all of the Level 2 CNSâ€™s within the Trust.

Measure 13-2N-104
On reviewing the MDT attendance spreadsheet, it was noted that personal commitment at MDT for Oncologists, Pathology and Specialist Palliative Care roles were not visible. This is due to being displayed as a speciality rather than individual attendance.

The MDT highlighted that Specialist Palliative Care and sometimes Histopathology only attend half of the MDT, the Panel were not assured that a fully informed discussion is taking place for all patients, due to these concerns, this measure is non compliant.

The HPB team have set up a single site ERCP Service. Beds are ring-fenced for urgent jaundice patients, allowing rapid treatment. The HPB team expressed concern, with regard to the EUS service being offsite from the Leicester General Hospital.

Measure 13-2N-112
During 2013, the East Midlands Cancer Network collapsed. This MDT has lead the way to re-establish this Clinical Reference Group. The HPB MDT Lead has pledged to lead this new Clinical Reference Group, they met as a group in January 2014, and this group have reviewed and ratified their guidelines.

Measure 13-2N-116
The HPB are in the process of collating their local Patient Experience Survey results. Having reviewed the results submitted for this review, patients feel that they are not given enough information with regard to Financial Help, Support Groups and Free Prescriptions. It is suggested that once all the results of the survey have been received, a concise action plan is required and submitted to the Cancer Centre.
The panel recognised that the team are piloting a patient support group and will commence in March 2014. The team are exploring an information App, however, funding is an issue.

The team are in the process of arranging education sessions for GPâ€™s with the aim of reducing unnecessary admissions, the process of a 2 week wait referral and the HPB service.

The team have commissioned their own website to target GPâ€™s and patients. With the aim of educating and communication to Health Care Professions outside of the Trust.

The MDT Co-ordinator expressed concern with regard to admin support for this service, which has become unmanageable due to the increase in patient referrals over the past year. It is estimated that 66 patients are discussed per MDT. The MDT Co-ordinator informed the panel that the main challenges are when requesting scans from referring hospitals, this becomes time consuming.

HPB CNSâ€™s expressed concern with regard to their increased workload, as wards become short staffed, the HPB CNSâ€™s have to cover the ward areas.

Final comments:

The panel felt that this MDT is an excellent well-coordinated team, showed excellent team working and provided a high standard of care to patients and should be congratulated on their achievements.

Summary of validation process

Panel
Trust Cancer Centre Lead Clinician
Cancer Centre Lead Nurse/Service Manager
Peer Review Project Lead
Patient Representation

Time: 11:30 MDT met with the panel to discuss the evidence submitted.

MDT Members in attendance:
Consultant Surgeon / MDT Lead Clinician:
Consultant Surgeon

Consultant Surgeon
Lead HPB Nurse Specialist
HPB Nurse Specialist
MDT Co-ordinator
MDT Co-ordinator

Organisational Statement

I, Mr Matt Metcalfe *(Validation Chair)* on behalf of UNIVERSITY HOSPITALS OF LEICESTER agree this is an honest and accurate assessment of the HPB MDT.

Agreed by Mr John Adler *(Chief Executive)* on 1st Apr 2014.