RCoA
Royal College of Anaesthetists

ACSA
Anaesthesia Clinical Services Accreditation

Anaesthesia Clinical Services Accreditation (ACSA)

Annual Review 2020–2021

Royal College of Anaesthetists | ACSA Anaesthesia Clinical Services Accreditation

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ACSA Clinical Lead statement

No one reading this Anaesthesia Clinical Services Accreditation (ACSA) annual review of 2020–2021 needs me to remind them how difficult it has been to continue with our normal working lives over the last 18 months. Obviously that is easy to recognise for those that deliver healthcare but it is equally true for colleagues who support us in our desire to improve the quality of that care. So I open this Chair's Statement by paying tribute to the indefatigable spirit, dedication and professionalism of the staff at the College and in particular the clinical quality team. They have not allowed ACSA to stand still but have continued to engage with departments, support, advise and accredit them on the ACSA journey. They have managed to do this in a way that has reflected the waxing and waning of the demands on clinical staff with the various waves of the pandemic, but always respectful of our (my) fatigue, stress and need to decompress. To the whole team I say thank you.

So what have we achieved over the last 18 months:

- the ACSA portal has been successfully launched, streamlining the whole accreditation process for departments
- we now have 41 accredited departments: an increase of nine newly accredited and three re-accredited
- the 2021 standards have been edited and published, these include 4 new standards on relating to the care of patients with tracheostomies and supporting those in clinical leadership roles
- engagement levels remain high with nine newly registered departments taking our total to 122 registered departments which equates to 74% of departments in the UK
- we have piloted and are now successfully running remote review sessions.

The challenges that remain:

- could ACSA accreditation ever be an entirely remote process? Will we miss tthe benefit of the onsite walk around by not meeting staff, and triangulating compliance with standards first-hand? The ACSA committee is unanimous in believing that the benefits of the face to face component of the peer-review visit are too great to lose. We hope to restart onsite visits in early 2022
- further engagement remains our goal and we have appointed two deputy ACSA Committee Chairs to support this and other work. Both Dr Emma Hosking and Dr Jon Chambers are highly experienced in the ACSA scheme and we look forward to working closely with them in the next year
- matching capacity to meet the demands of the scheme. We have two new accreditation coordinators: Daisy Rai and Liz Jackson. Both bring experience of accreditation schemes from other organisations and we look forward to working with them over the coming year
- So, 2020/21 has been a challenging time for everyone involved with ACSA, but I believe that through dedication, innovation and professionalism we can continue the quality improvement of services to our patients that is championed by ACSA.

Dr Russell Perkins

ACSA committee vice chairs

In order to support the growing workload associated with ACSA two vice chairs were appointed to the ACSA committee to support the clinical lead, each bringing their own expertise and experience to further develop the scheme.

Dr Emma Hosking

It's really exciting to be involved in a more senior way with the work of the ACSA committee. I'm an experienced clinical leader and have held clinical lead and director roles in anaesthesia, a hospital medical director role at Glan Clwyd Hospital and am currently the associate medical director for professional development in Betsi Cadwaladr University Health Board in North Wales.

Over the last few years I have completed many reviews and found them to be empowering for departments and inspirational for the review teams. It's been great to network with both clinical, college and lay reviewers. I've been tasked with a focus on improving the engagement of the devolved nations with the ACSA scheme. I look forward to working with our accredited departments in Livingstone (St. John's Hospital) and Bangor (Ysbyty Gwynedd) to raise the profile of the scheme in Scotland and Wales.

Dr Jon Chambers

I am a Consultant in Anaesthesia and Intensive Care Medicine at Dorset County Hospital. In addition to my role as vice chair of the ACSA Committee I am currently Lead Regional Adviser (Anaesthesia) for the College.

I became an ACSA reviewer in 2013, a lead reviewer in 2016 and led our department through our own accreditation in 2018. I have now led multiple visit teams and supported a number of departments as their College Guide. Through these roles, and as member of the ACSA committee, I have developed a detailed knowledge of the scheme.

My role as vice chair is to support the ACSA Team in the delivery of all aspects of the programme and have been specifically tasked with expanding engagement with the independent sector. The ACSA scheme has been adopted by many departments within the NHS as the benchmark for measuring both quality and safety of care. As a committee we believe that this should be mirrored within the independent sector and that ACSA should be promoted as the gold standard by which all clinical environments, wherever and whenever anaesthesia is delivered, benchmark themselves.

Our mission

It is our goal to improve and maintain quality and safety through benchmarking anaesthetic services and embedding continuous quality improvement. We will maintain our position as the leader for anaesthetic accreditation.

Our vision

Delivering excellence through world-class accreditation.

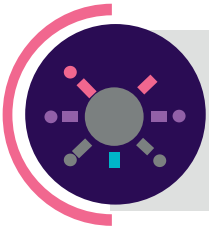
Our values

EXPERT

We are **experts** in the profession and delivery of accreditation in order to be effective in our mission to provide excellence for anaesthetic services.

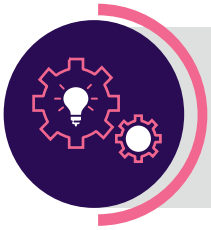
POSITIVE

We are constructive, collaborative and proactive. We focus on achieving **positive** outcomes for the workforce and patients.



INCLUSIVE

ACSA is **inclusive**, with the intention for all trusts, boards and healthcare organisations to assess against the national standards.



FORWARD-THINKING

Accreditation is advancing and we must be **forward-thinking**. We look for opportunities to innovate and improve, setting the national and international accreditation agenda.

AMBITIOUS

We are **ambitious** and are committed to leading and evolving anaesthetic accreditation.

Impact of the COVID-19 pandemic

The year 2020 was not the one anyone had planned and that is certainly true for the ACSA scheme. We were on course to deliver more visits in 2020 than in any previous year but this all came to a halt in March 2020. In recognition of the significant reorganisation taking place in hospitals, as well as considerations of safety, logistics and availability of clinical reviewers and departments, the decision was taken to pause onsite visits until such a time it was safe and practical to resume them. The decision was also taken to postpone publication of the ACSA standards which are usually updated on an annual basis. Extensions to deadlines were arranged and communicated to departments at all stages of their accreditation journey to acknowledge the limitations on their ability to progress under pandemic pressures.

The COVID-19 pandemic forced everyone to re-evaluate, adapt and consider new ways of working and that is exactly what the ACSA scheme has done. Recognising that onsite reviews may not be possible for some time, the scheme went on to adapt its model of review delivery to ensure it was able to continue in its mission of facilitating continuous quality improvement. By delivering elements of the review process remotely, the scheme has been able to support departments in progressing with their accreditation journey.

Hybrid model of delivery

Underpinning the consideration of what could/could not be delivered remotely was a position that any revisions to the process should provide an equivalent level of scrutiny as full onsite reviews so as not to reduce the robustness of assessment. Through consultation with our pool of reviewers and the ACSA committee, there was unanimous agreement that whilst certain elements of a review can feasibly be assessed remotely, a full accreditation could not be delivered entirely this way. Onsite triangulation is required to provide the same level of assurance that standards are truly being met before accreditation can be awarded.

Delivery of a select part of the review process was piloted initially. Termed the 'classroom session' this part of the review involves a presentation from the department to outline the remits of their service provision and any areas of difficulty and achievement. All self-assessed unmet standards and some other standards pre-selected by the reviewing team are then discussed in detail to inform recommendations for addressing any gaps. These are further informed by documentary evidence provided by the department in the form of policies, training records, minutes and audit data. These classroom sessions were piloted via MS Teams with targeted departments whose reviews were first to be postponed in 2020. Upon their successful trial and given the uncertain trajectory of the pandemic, we rolled out the delivery of further divorced elements of the review process. This included staff sessions with senior allied nursing staff, managers, consultants, anaesthetists in training and SAS doctors.

The remaining onsite elements of review are being piloted with select departments in late 2021, with the intention of rolling this out to all departments who have participated in the hybrid model early in 2022 as long as it is safe and practical to do so.

A new element of the review process was also introduced to gather further data on a department's engagement with ACSA from the perspective of staff groups. A set of surveys were designed to circulate to anaesthetists in training, SAS doctors and consultants. This has facilitated the collation of additional evidence on standards that require the direct feedback of clinicians working within a department. Such input has previously been reliant on the availability of individuals to attend the set staff sessions as part of the review. Not all staff may be available to attend these so the use of surveys enables wider representation as well as further point of evidence triangulation. This has been added to the review process as an enhancement rather than as a replacement for the staff meetings. Data from these surveys can be utilised by review teams to target particular areas of discussion when they meet together with various staff groups.

All these elements worked well being delivered remotely, and in most cases better than could have anticipated. But what does this mean for the future of ACSA reviews?

The ACSA team are in the process of consulting reviewers and departments who have engaged in the hybrid review process over the last 18 months to gauge what has worked well, what could be improved and what, if any, elements of remote assessment we should consider embedding longer term. The changed model has allowed departments to elongate their assessment process and receive interim reports before further triangulation. This has some obvious benefits as the staggered process allows departments to have targeted time to work on identified areas of improvement but consideration should be given as to whether this model generates more work for the scheme and puts pressure on capacity in the longer term. The number of dates to coordinate is greater as is the time commitment for reviewers as it is spread over a longer period. Further details will be shared as and when any firm decisions are made.

Current engagement with ACSA

A voluntary scheme for NHS and independent sector organisations, ACSA launched in 2013 and offers quality improvement through peer review. The College has aligned the scheme closely with the national regulators, such as the Care Quality Commission (CQC), Healthcare Inspectorate Wales (HIW) and Healthcare Improvement Scotland (HIS), who have included ACSA in their inspection frameworks and self-assessments. We have no official endorsement from Northern Ireland yet, although we continue to work on this.

Despite the challenges over the last 18 months, we have seen that ACSA continues to grow with an increasing number of registered departments. 74% (baseline 164 departments) of NHS departments have now registered with the scheme. In total, 41 departments, including an independent site have gained accreditation.

The degree of engagement with the scheme varies across the UK as demonstrated by the map on the next page.

Activity

In 2020, we carried out seven onsite review visits before the pandemic forced the postponement of all remaining scheduled visits.

The successful delivery of elements of the review process remotely has allowed us to assess ten departments between November 2020 and June 2021. By the end of 2021 seventeen departments will have been assessed in this way.

In 2020, we accredited five sites:

- North Bristol NHS Trust
- South Tees Hospitals NHS Foundation Trust
- Countess of Chester Hospital NHS Foundation Trust
- Frimley Health NHS Trust
- Leeds Teaching Hospitals NHS Trust

In 2020, we reaccredited three sites:

- Kingston Hospital NHS Foundation Trust
- St George's University Hospitals NHS Foundation Trust
- Torbay and South Devon NHS Foundation Trust

In 2021 (to June), we accredited four sites:

- Royal United Hospitals Bath
- The Pennine Acute Hospitals NHS Trust – Royal Oldham Hospital
- Betsi Cadwaladr University Health Board – Ysbyty Gwynedd Hospital (first in Wales)
- Bradford Teaching Hospitals NHS Foundation Trust

Image 1: Map showing ACSA engagement across the UK based on number of registrations

Feedback from departments

The ACSA process includes feedback obtained from the department after their onsite visit and published reports. This offers engaged departments the opportunity to provide formal feedback to the ACSA team. The feedback collected is considered confidential and is used for the purpose of improving the ACSA process.

The response rate is around 50% and the figures below include feedback received since the scheme began, in order to reflect a larger data set.

On average, the departments spent 27 months, from the point of registration, preparing for their review visit. Prior to formal registration with the scheme, departments assessed themselves as being 75% compliant with the standards. At the review visit, departments are on average assessed to have 9 unmet standards (6% unmet) and 6 standards met with recommendations (4%). On average, departments take 10.5 months from their review visit to achieve accreditation; it should be noted that this figure includes the time for the final review visit report to be drafted. All departments who responded agreed that their services had improved as a result of engagement with the ACSA scheme, that the scheme was beneficial and that they would recommend the scheme to a colleague.

As detailed earlier, we are gathering feedback data on the hybrid model of review delivery. Findings from this will be shared in the next review.

ACSA portal

The ACSA portal was launched in November 2020 to support our ever-growing ACSA community. The resource is open to those already engaged with the ACSA scheme or those wishing to express interest in seeking accreditation for the first time.

Once registered, the system provides anaesthetic departments across the NHS and independent sector, the ability to track and progress their ACSA journeys, collaborate with colleagues and engage with College ACSA staff in ways not previously possible.

A dashboard provides a summary of progress against the current ACSA standards, based on the information input into the self-assessment tracker. You can also see key information such as your assigned College guide, review dates and subscription information. The self-assessment tracker allows departments to review the ACSA standards and more easily carry out self-assessment, with users being able to RAG rate their progress, make notes and upload evidence against each standard. It also provides instant access to the mapped GPAS references and all items from the resource library, making good practice from other departments freely available.

Registering on the portal holds no formal obligation but by doing so the ACSA Team will be able to provide a quote for subscription and provide personalised support and advice. You can find out further details and register on the portal here.

Image 2: Screenshot of ACSA portal dashboard

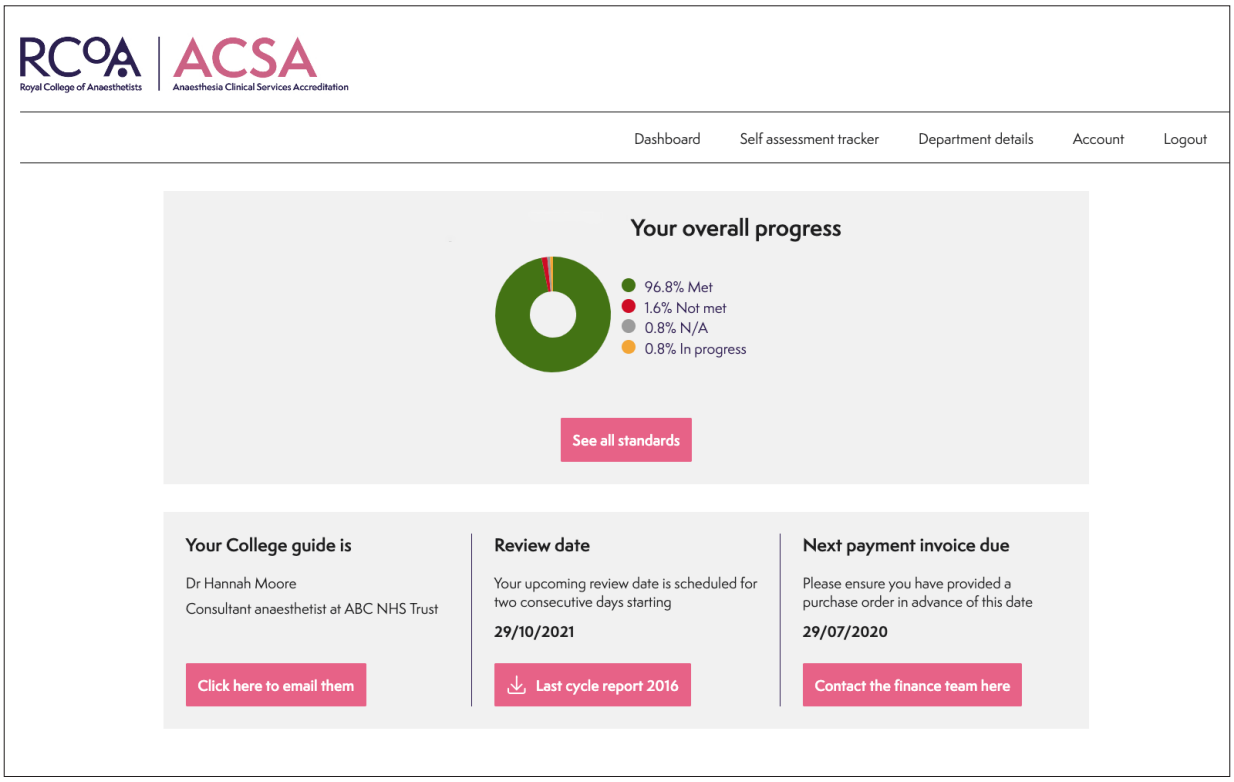


Image 3: Screenshot of ACSA portal self-assessment highlighting evidence upload

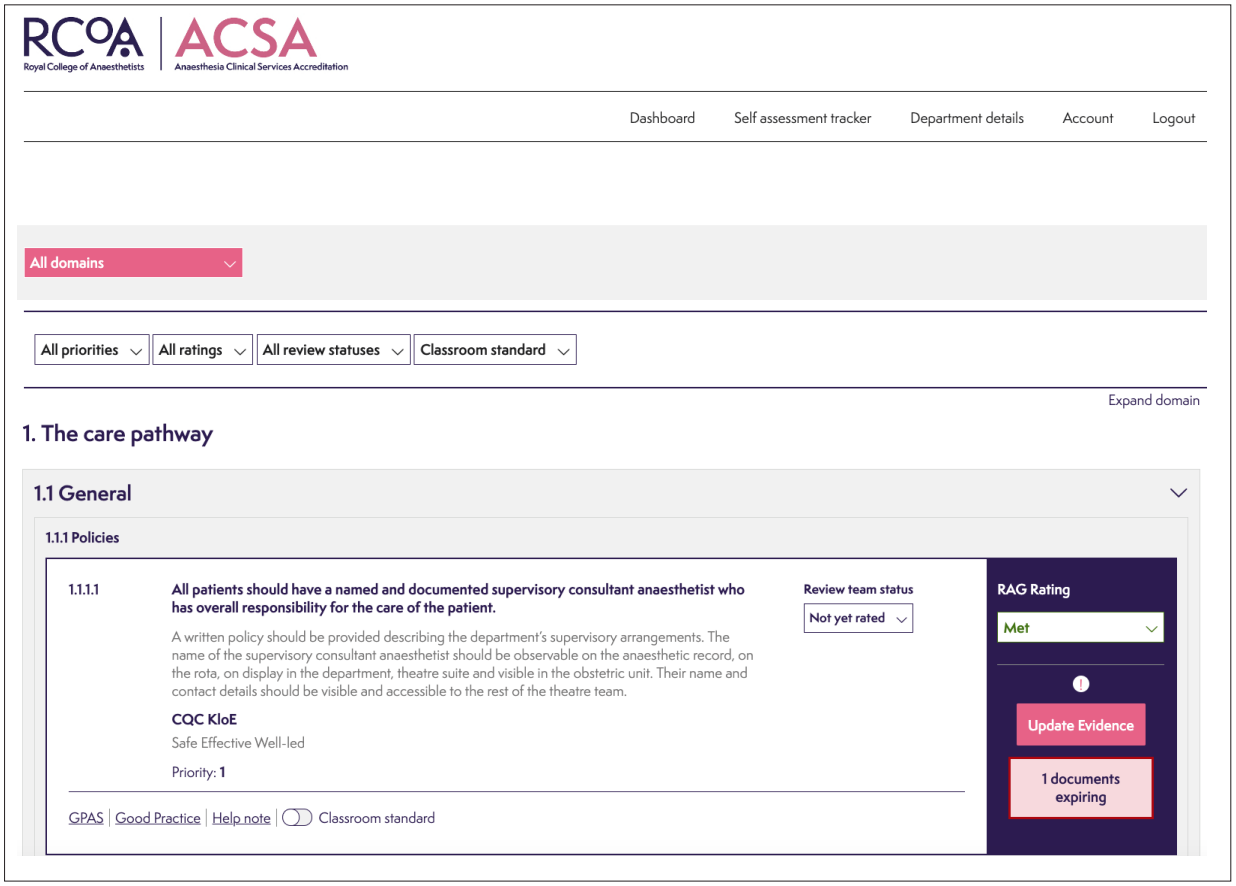
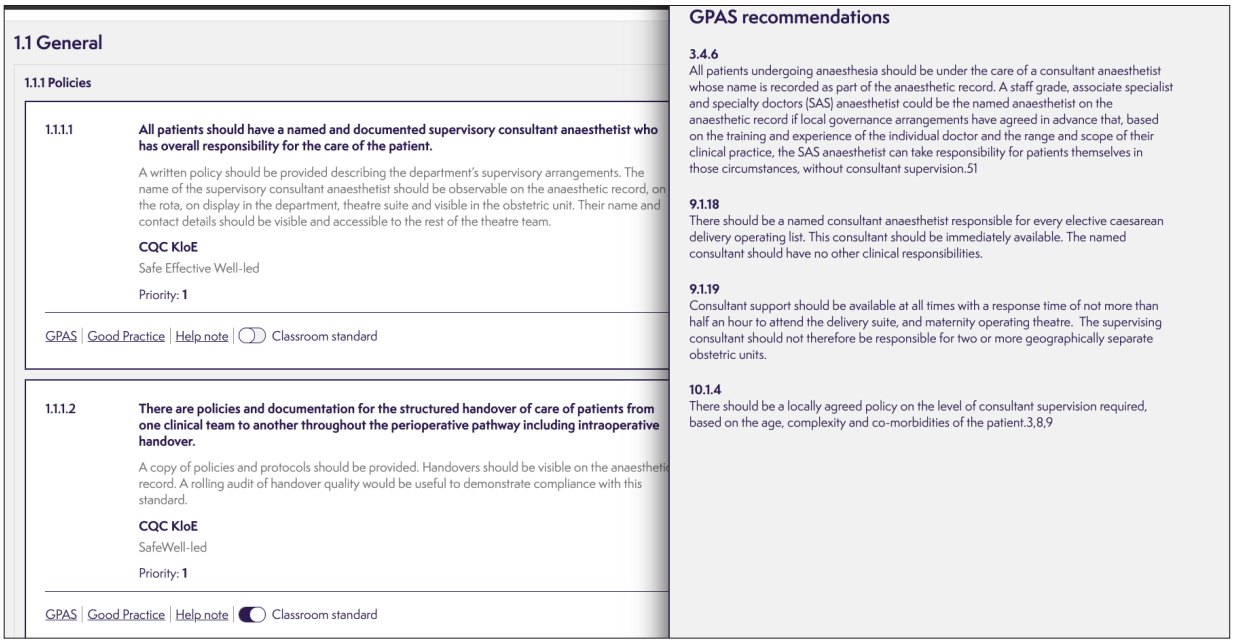


Image 4: Screenshot of ACSA portal self-assessment highlighting linked GPAS refs



Areas for improvement

We have now visited over 50 different anaesthetic departments and while every department is unique, we have identified some common themes.

Frequently unmet standards

There are a number of standards that are regularly assessed as unmet in departments visited by the ACSA scheme.

1.4.2.2 – All recovery staff should be trained to an appropriate level in life support and maintain their competencies.

All recovery nurses should maintain competency equivalent to ILS. There should always be at least one member of staff with competency equivalent to ALS immediately available to attend an emergency in recovery – this could be an anaesthetist if one is always immediately available. Immediately available means free to attend within a maximum of five minutes.

It is important to note that the competence required is equivalent to RC-UK's ILS and ALS standards; some departments find it more cost effective to develop in-house training courses. Internal training rather than an external course is accepted as equivalent if the content is considered satisfactory by the trust resuscitation training officer.

The ACSA committee recognise that the pressures of COVID-19 have disrupted the delivery of training courses and compliance levels are likely to have dropped over the last 18 months. In recognition of this, a temporary satisfactory minimum of 70% attainment has been deemed acceptable provided there are clear plans in place for the resumption of ongoing training as part of the recovery plan from COVID-19. This applies for similar training standards – 1.4.2.1, 1.6.1.3 and 1.6.1.4.

1.4.4.2 – Appropriate pathways are in place for the post procedural review of patients which includes criteria led discharge.

There should be a formal process to ensure the post procedural review of all patients is consistent and that there are clear discharge criteria in place. The process should be clearly communicated to staff, including trainees.

There is often a well-established process for obstetrics and pain but outside of this, departments can struggle to demonstrate that there is a robust process in place. Typically this standard is often unmet for one particular group of patients who should receive a post-procedural review – ASA 3-5 patients who are inpatients after surgery but not in a critical care facility and don't have complex pain needs. How to fill this gap depends on the number of patients to whom this applies. It is important to note that it is a review by a member of the wider anaesthetic team rather than necessarily an anaesthetist; if the numbers are small, critical care outreach may be the most appropriate team to refer these patients to. Departments might also have a process to refer patients to be reviewed by one of the on call anaesthetists the following morning. Where there are large numbers of ASA 3-5 cases there are logistical issues with reviewing all these patients face-to-face as it takes a considerable amount of time. Electronic systems offer another way to enable appropriate identification of patients requiring follow up. Over the last year the ACSA team have been presented with proposals for pragmatic electronic review systems that ensure patients are appropriately reviewed. In one example, NEWS2, PONV and pain scores are electronically recorded on a real time dashboard. These are then triaged each day by the duty floor anaesthetist who arranges an in–person review of any patients

flagged as a concern. As these systems become more embedded we will gather further information to form case studies for shared learning.

1.1.2.5 – The trust/board has a sedation committee with anaesthetic representation.

The Academy of Medical Royal College's 'Safe sedation practice for healthcare procedures' 2013 recommends that institutions in which sedation is carried out should establish an appropriate governance committee. The functions of this sedation committee should include:

- development and review of local guidelines; the review of pharmacovigilance of sedative drugs, including midazolam and flumazenil storage and use;
- the review of reported clinical incidents where sedation is a factor;
- annual audit of numbers of sedation cases and the incidence of complications within the institution;
- overview of staff training and continuing personal development in sedation practice.

Committee membership should include clinical teams using procedural sedation and there should be anaesthetic representation. Since this is a standard that requires buy-in from many different specialties within the hospital, it might prove difficult for an anaesthetic department to progress. Departments should note that all the bodies that represent the key specialties who would need to participate in a sedation committee have endorsed the Academy document. It is also worth noting that the standard does not specify the frequency of meetings for this committee; depending on the services delivered within the hospital, twice yearly could be sufficient. Furthermore, if sedation is only provided by anaesthetists then this standard may be considered non-applicable. Commonly requested evidence includes terms of reference, meeting minutes and the regularity of meeting occurrence.

2.2.1.2 – Local anaesthetic agents (ampoules and bags) must be stored separately from other drugs and intravenous fluids.

This standard remains the most frequently unmet ACSA standard. Any part of the hospital where local anaesthetic agents are kept for use by anaesthetic staff these must be 'stored separately' from other drugs and intravenous fluids – at the least this would be behind different doors which in practice means different cupboards. Human factors should be considered to ensure there is a conscious separate action (e.g. opening a separate door or locked box) required to access local anaesthetic agents.

Often, but not always, it is commonly clinical areas remote from main theatres that are the culprit. This may suggest that the whole multidisciplinary team is not bought in to the change that has been made or understand the importance of this change. It may be helpful to discuss the incidents from which this standard arises (such as those in NAP3) to help embed the change.

2.4.1.2 – An emergency call system is in place and understood by all relevant staff. Where there are multiple locations the system must clearly indicate in which location the emergency is occurring. This standard pertains to being able to summon anaesthetic assistance in an emergency. Where there are multiple locations, an appropriate system should have both audible and visual elements so that the location of the emergency can be identified.

The reasons why this standard is unmet vary. In older hospitals, they may not have been part of the original theatre build and retrofitting them can be costly. This does not mean it is impossible – several accredited departments have used ACSA as leverage to obtain funding to bring their theatres up to standard. Others have found alternative wireless systems which are cheaper than traditional emergency call systems.

Another common issue is areas remote from main theatres such as MRI. We are pragmatic about this and the ACSA committee will consider the appropriateness of any local solution for specific local circumstances particularly in these remote areas. This may include bleeping the on call anaesthetist directly.

An ideal way to test your arrangements is to run an unannounced in-situ simulation – this should reveal any gaps in your provision and audit data demonstrating response times can be used to evidence the suitability of the systems in place.

Areas for development

The Good Department

A new GPAS chapter entitled 'The Good Department' was published in July 2021. GPAS chapters have previously focused on a particular aspect of clinical service delivery. However, experience gained through the delivery of the ACSA scheme has identified a requirement in GPAS to describe what it is about a department of anaesthesia itself, beyond the different aspects of the clinical service delivery, that contribute to a successful department. These departments are cohesive and are able to provide a high quality service across the totality of the clinical service. What makes a department one in which anaesthetic and support staff want to and feel able to work and stay working, take on extended roles, contribute positively by improving the standards of care for patients and engage in educational activities.

The Good Department chapter has been developed to address this requirement, describing current best practice for developing and managing a safe and high quality anaesthesia service in terms of the non-clinical aspects of the service that underpin the clinical provision. The chapter makes recommendations in terms of: leadership, strategy and management; workforce; education and training; clinical governance; support services, for the good department. The recommendations will be taken forward for inclusion in the next iteration of the ACSA standards which will be published in 2022.

The future

Our Strategic Plan 2020–2025

The ACSA scheme has developed substantially in its first years of operation both in terms of the process and the standards and our strategic plan sets out the vision for ACSA over the next five years and agreed priorities to enable the scheme to develop and maintain its reputation as a leader in the field of anaesthetic accreditation.

It is intended for this strategy to support the College in achieving its overarching goal to engage all UK NHS hospitals in ACSA in a bid to ensure it remains a pre-eminent peer review scheme.

The ACSA strategy spans 2020-2025 and will therefore be carried into the College's new 2021-2026 strategy when published. It was published before the onset of the pandemic so is currently under review to update the objectives and timescales where necessary.

Quotes from accredited departments

Dr Tony Shambrook, ACSA Lead

Ysbyty Gwynedd (first hospital in Wales to be accredited in March 2021)

"We are extremely proud and honoured to be the first hospital in Wales to receive ACSA accreditation. It has been a long process over two years to meet all the standards to achieve this award. A great deal of work has gone on behind the scenes, from investing in new equipment to updating policies and guidelines to ensure we achieved it.

Our main focus is putting our patients first and ensuring patient safety is at the heart of everything we do. The ACSA process has helped to highlight how we can improve as a department to ensure we are delivering safer patient care and better patient experience."

Dr Andrew Brammar, ACSA Lead

Royal Oldham Hospital (accredited March 2021)

"We are delighted to have achieved ACSA Accreditation and extremely proud of the way our department has worked with very many people across our hospital services to meet the standards required. It really has been a team effort.

It has been very rewarding to evaluate every aspect of our anaesthetic and theatre services, to highlight areas of good practice whilst using the process to drive forward improvements in service provision and patient care. We are particularly proud that we were able to meet the last outstanding standards through targeted multidisciplinary staff training and strengthened preoperative assessment provision despite the challenges caused by COVID-19"

The input from the external ACSA review team made these improvements easier to achieve, and provided us with much positive feedback that we hope will bring benefits in terms of recruitment and staff retention.

Dr Karl Brennan, Clinical Director

Sheffield Teaching Hospitals NHS Foundation Trust (reaccredited in May 2021)

"We are delighted to have renewal of this prestigious award. This is the culmination of over five years' hard work, and a fantastic acknowledgement of the whole team's ongoing commitment to maintaining the highest standards of care. We are exceptionally proud of the care we provide to patients across the city, and as well as successfully completing yearly self-assessments, revalidation also involved a formal site visit. The formal visit took place just as the team were preparing for the onset of the COVID-19 pandemic, so we would like to take this opportunity to thank the review team from the RCoA for their professionalism in particular during this time as they as they were hugely respectful of our desire to maintain our services during this time. It has also been a real privilege to benefit from the expertise of our peers throughout the reaccreditation process, and revalidation has empowered us to put in place systems to raise our own game, highlighted opportunities to further improve care, and the high standards of care we are continuing to offer patients."

Dr Maria Garside, ACSA Lead

Bradford Teaching Hospitals (accredited in May 2021)

ACSA is peer review at its best. The RCoA has developed this very robust and supportive process, which will benefit every department that fully engages with it. Our Executive board was initially hesitant, perhaps due to others having had an experience of peer review being burdensome and less helpful. However, completing the ACSA process to the point of accreditation has been an overwhelmingly positive experience for us as a department and a Trust.

It is, certainly, a big commitment for any department and includes a lot of hard work, teamwork and persistence over a few years. As the ACSA lead, I am glad to have had the opportunity to work closely with so many other departments which have a bearing on the delivery of our anaesthetic services because the review took a huge amount of preparation and involvement from all these areas.

We were inspected in detail and complete compliance to all standards has been required unwaveringly. In this way, ACSA has driven us to improve our services, even in areas that were difficult to change. As well as all the policy updates and smaller initiatives, some of the bigger changes have included getting new cell salvage equipment, much better training for our theatre staff, a new intranet site for our department and improvements in patient experience for children and their carers.

Now that we are accredited, I think the next phase is the most exciting. Having gone through the accreditation process, we have a solid foundation for maintaining high quality services moving forward. The ACSA process will continue to benefit us year on year as it serves as a guide and a benchmark for continuing improvement. We now look forward to giving evidence for compliance with the newest standards next year. The ACSA team at the RCoA have always been readily available to provide help, advice and support at every stage. Thanks to all at the RCoA for the way that you have supported us to become the best that we can be.

Appendix 1

Accredited Sites

Homerton University Hospitals NHS Foundation Trust	Alder Hey Children's NHS Foundation Trust
Harrogate & District NHS Foundation Trust	Wirral University Hospitals NHS Trust
University Hospitals Plymouth NHS Trust	Liverpool University Hospitals NHS Foundation Trust
St George's NHS Foundation Trust	Epsom & St Helier University Hospitals NHS Trust
Kingston Hospital NHS Foundation Trust	Worcestershire Acute Hospitals NHS Trust
Torbay & South Devon NHS Foundation Trust	NHS Lothian: St John's Hospital
St Helen's & Knowsley Teaching Hospitals NHS Trust	East Lancashire Hospitals NHS Trust
Sheffield Teaching Hospitals NHS Foundation Trust	Buckinghamshire Healthcare NHS Trust
Portsmouth Hospitals NHS Trust	Norfolk & Norwich University Hospitals NHS Foundation Trust
Salford Royal Foundation Trust	Airedale NHS Foundation Trust
National Hospital for Neurology & Neurosurgery	Royal Manchester Children's Hospital
South Warwickshire NHS Foundation Trust	Dudley Group NHS Foundation Trust
York Teaching Hospitals NHS Foundation Rust (York Hospital)	North Bristol NHS Trust
Manchester University Hospitals NHS Foundation Trust (Manchester Royal Infirmary, Manchester Royal Eye Hospital, St Mary's Hospital and Trafford General Hospital)	South Tees Hospitals NHS Foundation Trust
Bolton NHS Foundation Trust	Countess of Chester Hospital NHS Foundation Trust
The Walton Centre NHS Foundation Trust	Frimley Health NHS Trust
Benenden Hospital	Leeds Teaching Hospitals NHS Trust
University Hospitals Dorset NHS Foundation Trust (Royal Bournemouth Hospital and Christchurch Hospital)	Royal United Hospitals Bath
Dorset County Hospital NHS Foundation Trust	The Pennine Acute Hospitals NHS Trust (Royal Oldham Hospital)
Derby Teaching Hospitals NHS Trust	Betsi Cadwaladr University Health Board (Ysbyty Gwynedd Hospital)
Lancashire Teaching Hospitals NHS Foundation Trust	Bradford Teaching Hospitals NHS Foundation Trust

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