

**Final Report of the Fifth National Burns Annual Mortality Audit (2018-2019)  
United Kingdom and Republic of Ireland  
1st July 2019**

*In June 2019, the 5<sup>th</sup> annual audit meeting was held, and almost all specialised burn services from across Great Britain and Ireland participated. This document sets out the background and context to the audit meeting, provides a synopsis of the event and makes proposals for future national audit meetings.*

**1 Introduction**

- 1.1 The NHS England National Standards for Burn Care requires all burn networks to undertake an annual, Morbidity and Mortality audit. In late 2014, it was agreed by the Clinical Leads for the four burns Operational delivery Networks that a nationally consistent approach to M&M audit would be made for the audit year, 2014-2015. In addition, it was also agreed that there should be a first, national mortality audit.

This first truly national audit, held in June 2015, was very successful and it was agreed at that meeting, that an annual event would take place. Since 2016, an invitation to participate has been extended to all services in the United Kingdom and Republic of Ireland.

- 1.2 The purpose of the audit is to add an additional layer of governance and scrutiny to the existing burn service & network audit function, and to support services and networks in sharing experiences and good practice, with the aim of improving patient outcomes and quality of care.
- 1.3 In 2018, the requirement for burn services in England and Wales to conduct M&M audit at a network and national level, was incorporated into the published *BBA National Standards for Provision and Outcomes in Adult and Paediatric Burn Care*.
- 1.4 The 2019 audit meeting was again hosted by the Midlands Burn Care Network and held at the Queen Elizabeth Hospital, Birmingham.

Prof. Peter Vogt, Director of the Department of Plastic, Aesthetic, Hand and Reconstructive Surgery of the Hannover Medical School, chaired the meeting, and over 100 senior burns clinicians attended, representing every burn service in England, Wales, Scotland and the Republic of Ireland.

**2 Methodology and Process**

- 2.1 This 2019 audit has continued the process of selecting cases. In February 2016, it was agreed that for services in England and Wales, the mortality audit cases would be chosen at each of the Burns Operational Delivery Network (ODN) audit meetings. Each ODN holds an annual mortality audit and *all* deaths are presented.

It was agreed that these local ODN meetings were an appropriate way of identifying cases that were outliers (scored) or were unusual in some other way. It was agreed that the iBID system would be utilised to help "validate" the cases that services presented. This would serve two purposes:

- As a baseline of knowledge for all services, as they made preparations for the network audit;
- As a tool, to measure the accuracy and utility of the iBID system itself.

Services in Scotland, Northern Ireland and Republic of Ireland were invited to identify cases in a similar way, although it was recognised that iBID was not available to them to validate their cases.

- 2.2 At the 2019 meeting, each service presented their cases using a template originally developed by the burn centre at Morriston Hospital, Swansea, and amended following the 2017 meeting. This included:
- An overview summary of all new referrals in each burn service (in-patients and out-patients, for adults and children and categorised by severity);
  - A summary of all paediatric resus / ventilated cases;
  - A summary of all serious incidents investigated under the NHS Serious Incident Framework;
  - A summary analysis of all deaths, providing high-level details of all burn mortalities in 2018-2019, including demographic and clinical information and the Modified Baux score.
  - A presentation time-line for the cases identified as outliers, showing the key events and interventions during the patient episode;
  - A presentation time-line for cases identified as exceptional or unexpected survivors.

### 3 Professor Dr Peter Vogt – Chair’s Report

- 3.1 It was a great honour to be invited to chair this National Burns Annual Audit 2018-2019. Being well attended by medical burn specialists and professionals of the UK and Ireland the meeting was organised by Mr. Naiem Moiemmen and Pete Siggers.

Presentations of serious incidents, unexpected deaths as well as unexpected survivors were discussed in an open, honest and scientific way. All cases had been previously selected and reviewed for presentation concluding with a synoptic analysis of the event.

The interaction of burn networks was demonstrated nicely by the Northern, South Western and Midland Burn Care Networks.

- 3.2 The format appeared highly efficient, as no statistics with skewed results of compiled data but individual cases with thorough lessons to be learnt were presented.

In particular the allocated time allowed for intense discussion by all participants and in the final conclusive discussion the most important future topics could be proposed by the audience. They will be reviewed and prepared for the 2020 meeting.

- 3.3 In particular the following aspects were intensely discussed:

3.3.1 • **Infection.**

Infectious problems, as a continuous threat upon burn patients, was intensely discussed with specific attention to Aspergillus infection, as a rare life-threatening complication. Suspicion should be directed at environmental factors (barns, greenery) as well as diagnostic tools (bronchoscopes) as sources of early infection.

In the same context, MRSA breakout and its late recognition were intensely elaborated, and it was agreed that early signs of infection in grafts and burn wounds should be addressed as soon as possible, in order to prevent graft loss and sepsis. As occasionally enzymatic debridement (ED) and repetitive surgical procedures was involved, it was discussed to establish better protocols for use of ED.

3.3.2 • **CPR and ventilation.**

CPR at scene was intensely discussed as a recurrent negative predictor of survival in adults and also in children.

Furthermore, the importance of secure airways was unanimously agreed upon and the expert opinion of the audience stressed that serious incidents of airways (incidental extubation, tube displacement) as potentially fatal sequels have to be avoided at all consequences. The good experience of centres performing simulation of critical incidents is appreciated by the participants. Related to the challenge of neuro versus lung protective ventilation, an intense discussion occurred around the priorities in critical care ventilation protocols.

3.3.3 • **Discharge and referral quality.** T

This is an ongoing challenge to all centres in both directions. Direct transfer of the elderly into the previous social environment may be critical, if residual wounds of the lower extremities are present and impose a risk for bone or joint exposure. A transition program for chronic wounds may be an option.

3.3.4 • **Surgical strategy.**

The standard of early excision of deep burn wounds is established in all centres and impressive results even in extensive burns in conjunction with thorough volume replacement are evident.

The management of patients in shortage of available beds may still be a challenge and mortality due to allocation in the hospital into non-experienced sectors must be avoided (risk of Mortality of patients on different wards if moved in the hospital). However, the well-functioning burns networks are proof of the effectiveness and efficiency of a collaborative approach.

3.3.5 • **Secure airways/ techniques of tracheostomy.**

Tube displacement remains a threat in the intense multidisciplinary management of burn patients. An intensive discussion on the best standards for secure airways took place and specific problems such as in very obese patients were elaborated. In this context alternative techniques of tracheostomy (longitudinal incisions versus tracheal flap techniques) were discussed.

3.3.6 • **Incidental non bacterial infection and additional disease affecting burns outcome.**

A discussion about TEN and Herpes Zoster Virus as confounding factors negatively affecting the prognosis in severe burns showed that these factors have to be always considered. The potential of viral screening was appreciated.

A discussion of TEN in children and adults circled around the idea to share the experience with dermatologists, as they treat a considerable number of patients. This is something to consider in the future. Liver function impairment in minor burns neurodegenerative affection are confounding factors that merit attention during all stages of the burn injury.

3.3.7 • **Report of the admissions group.**

A presentation was given on the transfer of patients to burns services. It became obvious that the majority of patients are referred indirectly, while direct admissions are seen for burns >40% in almost all patients. The majority of mortal cases are derived from indirect admissions, while mortality is not linked to transport time, hypothermia occurs more frequently in direct admissions.

Hypothermia is still a confounding factor in resuscitation of burn patients. Suggestions for a greater study in UK were made.

3.3.8 • **Elderly burn patients.**

Decision making in the elderly is an increasingly important aspect in the growing population of elderly burn patients. Various aspects were discussed, including the wishes of patients and the provision of palliative care.

Frailty as a confounding factor in the whole of medicine and burn is recognised and a discussion was pursued on frailty as a predictor and the necessary adjustments to burns (validation of the Canadian Rockwood Clinical Frailty Scale).

3.3.9 • **Paediatric burns.**

A discussion took place on paediatric resuscitation and a discussion of further development of the data set in order to establish a discrimination of subsets. Other opinions suggest maintaining the status. The case load and distribution of burns severity of the paediatric centres was given, while no clear opinion about the importance of clustering more severe burns in fewer centres was given.

3.3.10 • **Inhalation trauma and Extracorporeal lung support.**

Inhalation trauma as a major prognostic factor was intensely discussed and the importance of (early) bronchoscopy findings was stressed. ECMO is a technology that is being used more frequently while the burn team has to rely on the support of cardiac surgery and their experience related mainly to cardiac patients.

The audience discussed that access and indications have to be evaluated and defined specifically for the burn patients in the future.

3.3.11 • **Cultured skin replacement.**

In the treatment of very extensive burns, the availability of biological (living) skin replacement may be a significant problem as many companies have terminated skin culturing as a service. A Suisse product has been used successfully in a case and clinical studies are to be expected soon.

3.3.12 • **Post mortem.**

Post mortem was discussed intensely as the information gained is not sufficient. Reasons discussed are low interest of the coroner, low frequency of post mortem and overwhelming work load. Also, the lack of additional information compared to what clinically is already evident.

### 3.4 Chair's summary

The national mortality audit is a unique format of an open but confidential discussion, led by the passion of all participants for the improvement of burn care. The 2019 audit concentrated on areas that are pertinent to burns care or will become more important in the near future.

The contributions were of high standard and stimulated productive discussions. A particular feature is the joint effort of both the burn professionals and the NHS in this approach to improve health care in the UK and Ireland.

It was an honour and privilege to participate in the 2019 National Burns Mortality Audit – United Kingdom and Republic of Ireland.

*Prof. Peter Vogt,  
Director of the Department of Plastic, Aesthetic, Hand and Reconstructive Surgery  
Hannover Medical School*

## 4 Joanne Bowes - Paediatric Resuscitation

4.1 Fortunately, the number of children who die each year in the UK from burn injuries continues to be very low. For the first time last year we therefore decided to look at other outcome measures, namely children who require intubation and ventilation, in addition to mortality. This year we repeated the audit and were delighted to be able to include even more burn services in the analysis, receiving contributions from England, Ireland, Scotland and Wales.

Service	Number of patients	Number of patients intubated	Total number of ventilator days	Number of days intubated per % TBSA burn
Alder Hey	6	1	5	0.45
Belfast	10	0	0	
Birmingham Children's	24	4	141	0.7
Bristol	11	1	12	Pt with TENS
Chelsea and Westminster	18	1	7	0.175
Glasgow	6	4	32	0.31
Manchester	11	3	29	0.53
Newcastle	5	2	6	0.2
Nottingham	6	0	0	
Pinderfields	7	0	0	
Salisbury	1	0	0	
Sheffield	6	1	2	0.14
Stoke Mandeville	12	0	0	
St Andrew's	33	10	23	0.07
Swansea	3	1	14	0.3
Queen Victoria Hospital	2	0	0	
<b>Total:</b>	<b>161</b>	<b>29</b>	<b>272</b>	

- 4.2 Of the children intubated, 4 were intubated for less than 24 hours, 4 for 24-48 hours and the remainder for >48 hours, with all but one very seriously injured patient intubated for less than 17 days.

Service	Total number of patients
Alder Hey	1
Belfast	1
Birmingham Children's	7
Chelsea and Westminster	1
Glasgow	4
Manchester	3
Newcastle	2
Sheffield	1
St Andrew's	7
Swansea	1

#### 4.3 Discussion:

As can be seen, the number of children with burn injuries who require intubation and ventilation is very small, with a correspondingly low total number of ventilated days. Clearly a small number of services are caring for the majority of children with centre level burns, although we did not specifically collect data on children with >20% full thickness burns who were intubated for less than 24 hours. However, we can expect this number to be small.

**We intend to repeat this audit for the period April 2019 to March 2020 and hope to further enhance the overall picture of paediatric burn care in the UK by specifically collecting data on TENS / Necrotising Fasciitis, as well as data to enable burn centre activity to be more accurately demonstrated.**

*Joanne Bowes  
Consultant Anaesthetist  
Morrison Hospital, Swansea*

## 5 Transfer Audit - Transfer times and their impact on burn mortality

Following discussions at the 2018 National Audit meeting, it was agreed that a pilot audit would be undertaken to assess the impact of transfer time on mortality of burns patients. The work was led by the burns team at Stoke Mandeville Hospital, and the following section provides a short summary of the audit and findings.

### 5.1 Transfer Times and Their Impact on Burns Mortality: LSEBN

Oliver Manley, Kaneka Bernard, Matt Pywell, Bilal Rafique, Quentin Lew, Mampreet Sagoo, Ankit Mishra, Nora Nugent, Jorge Leon Villapalos, David Barnes, Alexandra Murray.

Aim: To assess the impact of transfer time on mortality of burns patients

- April 2016 – March 2018
- Inclusion
  - Adult burn > 15%
  - Paediatric burn > 10%
  - Inhalational injury
  - Data from 4 units (Stoke Mandeville Hospital, Chelsea and Westminster Hospital, Queen Victoria Hospital and Broomfield Hospital)

5.2	Demographics	Paediatric	Adult	Overall
	Number	56	92	148
	TBSA Median (IQR)	13 (11 – 17)	25 (18 - 35)	20 (13 – 29)
	Male %	52	68	62
	Burn Cause %			
	Scald	86	18	44
	Flame	7	70	46
	Flash	2	8	5
	Other	5	4	5
	Inhalational Injury	0	27 (29%)	27 (18%)

5.3	Admission Types	Direct admission	Indirect admission
	Admission type %(n)	11.4 (17)	88.5 (131)
	Time from injury to burns service assessment*	2.5 (1.8 – 4.3)	7.5 (6.0 – 10.1)
	Time from referral to burns service assessment*	1.5 (0.2 – 2.5)	4.6 (3.3 – 6.8)
	Time to start resus fluids*	2 (1.7 – 3.75)	2.25 (1.43 – 3.5)

### 5.4 Key findings

Only 11.4% admissions were direct therefore heavy reliance on inter-hospital transfers and pre-hospital teams.

- 7.5 hours mean time for transfer of indirect referrals.
- Fluid resus started in a timely manner in both groups.
- 34% of indirect transfers had a core temp < 36.8 on arrival at burns service.
- Out of the 17 deaths, 82% of these occurred in the indirect transfer group.
- In those without inhalation injury, there was a 10% intubation rate in indirect group versus 0% in direct group. Intubation and indirect transfer strongly

### 5.5 Conclusions

5.5.1 The overall conclusion from this small study is that mortality is not linked to transfer time of burns patients. The data is encouraging, and stronger conclusions may be possible with national data, collected over a longer period.

5.5.2 The majority of patients are admitted indirectly, with a heavy reliance on peripheral hospitals and ambulance teams.

Hypothermia remains a confounding factor in resuscitative burn patients and this suggests that there must be continue education programmes to improve outcomes.

- 5.5.3 As expected, patients presenting direct to a hospital with a specialised burns service are seen more quickly.

**Further research into the morbidity would likely reveal the impact of time as a predictor of inpatient/ITU stay**

*Alexandra Murray*

*Burns and Plastic Surgeon*

*Stoke Mandeville Hospital Chair of the London and South East Burn Network*

## **6 Anaesthetics and Critical Care**

*During the meeting lunch break, a “break-out” session was organised for members of the Burns Multi-Disciplinary Team, working in anaesthetics and critical care.*

- 6.1 Following the positive feedback from last year’s meeting, an Anaesthetic and Critical Care Breakout session was again held this year during the lunch break.

The session was led by Dr Tomasz Torlinski and Dr Randeep Mullhi who are both Consultants in Burns critical care at University Hospitals Birmingham (UHB) NHS Trust. The leading theme for this year’s session was temperature management in major burn injuries.

- 6.2 Dr Torlinski presented work from a recent retrospective audit at UHB involving patients admitted to the critical care unit with major burns (TBSA  $\geq 20\%$ ), over a two-year period.

The main objectives of the audit were to determine adherence to local UHB or International Society for Burn Injury (ISBI) guidelines for temperature management. UHB guidelines recommend the maintenance of a core body temperature in the range  $38.5 \pm 1^\circ\text{C}$  in patients with major burns whereas the more liberal ISBI guidelines recommend maintaining the core and peripheral body temperature above  $36^\circ\text{C}$ .

- 6.3 Dr Mullhi then discussed a National Burn Temperature Management Survey that was being distributed to all Burn centres and units via an online link. The idea of the survey was to gather information nationally on current temperature management practices.

The group agreed that this was a valuable piece of work that would hopefully add to this area of Burns critical care knowledge.

- 6.4 The presentations generated lively debate about temperature management with attendees sharing their own experience. It provided the opportunity for the group to hear how other centres and units manage temperature maintenance.

- 6.5 The informal feedback from the attendees was that this was a really valuable session as it allows physicians working in the areas of both Burns anaesthesia and critical care to share their ideas.

**The attendees were keen that this session be maintained for future meetings and they expressed interest in helping to organise them.**

*Drs R. Mullhi and T. Torlinski*

*Anaesthetics and Critical Care*

*Queen Elizabeth Hospital, Birmingham*

## 7 Overall Conclusions and Recommendations

7.1 Clinicians attending the meeting agreed that this 2019 audit event had again been an overwhelming success. A number of common themes, highlighted in the Chairs report, emerged from the meeting:

- **Accidental extubation: the need for clear guidelines, education and training;**
- **Consideration to be given, to adding a frailty score into the calculation of expected / unexpected deaths, particularly for patients over 65.**
- **The paediatric resus audit should be repeated for the 2020 meeting. TENs / SJS and other non-burns skin loss cases should be included but analysed separately.**
- **The use of ECMO in burn care should be further assessed.**
- **The “transfer” audit should be rolled-out nationally (England and Wales) but undertaken as a prospective audit, over a six-month period.**

7.2 It was agreed that the audit process and methodology should be refined for future years.

- **The network and national audit presentations should be reordered in 2020**
  - All paediatric cases (all mortalities)
  - All adult cases (selected mortalities)
  - All unexpected survivors
- **The summary analysis of mortality cases should be enhanced to clearly indicate:**
  - Expected mortalities
  - Comfort care / TLC
  - Unexpected / actively treated
  - Out-reach
- **The national audit meeting greatly benefits from having an external / independent chair. This should be extended into each of the local network M&M audit meetings.**

### ❖ ACTION

The ODN Clinical Leads and Managers, for England and Wales and working within the National Burns ODN Group, will review the comments and recommendations discussed at the meeting and will seek to include them in the NBODNG Work Programme for 2019-2020.

7.3 **The 2019 National Burns Mortality Audit will be held on Tuesday 30<sup>th</sup> June 2020.**

**Mr Naiem Moiemem**  
Burns and Plastic Surgeon,  
Queen Elizabeth Hospital Birmingham  
Clinical Lead, Midlands Burn ODN

**Pete Saggars**  
LSEBN Network Manager  
Chair, National Burns ODN Group

November 2019



## APPENDIX 1 – Participating Services

<b>England and Wales</b>	
<b>Northern Burn Care Network:</b>	<ul style="list-style-type: none"> <li>– Pinderfields, Wakefield</li> <li>– Alder Hey Hospital, Liverpool</li> <li>– Preston, Lancashire Teaching Hospitals</li> <li>– Royal Victoria Infirmary, Newcastle</li> <li>– Manchester Burns Services</li> <li>– Mersey Burns Services</li> <li>– Sheffield Burns Services</li> <li>– James Cook Hospital, Middlesbrough</li> </ul>
<b>London &amp; South East of England:</b>	<ul style="list-style-type: none"> <li>– St Andrews, Broomfield Hospital, Chelmsford</li> <li>– Queen Victoria Hospital, East Grinstead</li> <li>– Chelsea &amp; Westminster Hospital</li> <li>– Stoke Mandeville</li> <li>– Oxford John Radcliffe Hospital</li> </ul>
<b>South West UK Burn Care Network:</b>	<ul style="list-style-type: none"> <li>– Morriston Hospital, Swansea</li> <li>– Bristol Royal Children’s Hospital</li> <li>– Southmead Hospital</li> <li>– Salisbury General Hospital</li> <li>– Derriford Hospital, Plymouth</li> </ul>
<b>Midland Burn Care Network:</b>	<ul style="list-style-type: none"> <li>– Birmingham Children’s Hospital</li> <li>– Nottingham University Hospital</li> <li>– University Hospital Birmingham</li> <li>– Leicester Royal Infirmary</li> <li>– Royal Stoke University Hospital</li> </ul>

<b>Republic of Ireland</b>	– Dublin
<b>Scotland</b>	– Glasgow
<b>Northern Ireland</b>	– Belfast

**APPENDIX 2 - Attendance**

<b>First name</b>	<b>Last Name</b>	<b>Burns Service / Organisation</b>
Moataz	<b>Abdelrahman</b>	<i>Royal Manchester Children's Hospital</i>
Skaria	<b>Alexander</b>	<i>Nottingham University Hospitals</i>
Afeda Mohamed	<b>Ali</b>	<i>Birmingham Children's Hospital</i>
Mohamed	<b>Aly</b>	<i>Manchester Burns Service (Adults &amp; Paediatrics)</i>
Mohammad	<b>Anwar</b>	<i>Pinderfields</i>
Anne	<b>Baines</b>	<i>Royal Preston</i>
Harish	<b>Bangalore</b>	<i>St Andrews Burns Centre</i>
David	<b>Barnes</b>	<i>St Andrews Burns Centre</i>
Laura	<b>Bennett</b>	<i>Nottingham Children's Burns Unit</i>
Kaneka	<b>Bernard</b>	<i>Stoke Mandeville Hospital</i>
Peter	<b>Berry</b>	<i>St Andrew's</i>
Joanne	<b>Bowes</b>	<i>Welsh Centre for Burns</i>
Richard	<b>Browne</b>	<i>QEHB</i>
Lorna	<b>Burrows</b>	<i>Southmead Hospital, North Bristol NHS Trust</i>
Louise	<b>Campbell</b>	<i>Alder Hey</i>
Olivia	<b>Cavan</b>	<i>Nottingham University Hospitals</i>
Tom	<b>Challoner</b>	<i>QEHB</i>
Elizabeth	<b>Chipp</b>	<i>QEHB</i>
Cameron	<b>Clarke</b>	<i>Royal Victoria Hospital</i>
Ian	<b>Clement</b>	<i>Royal Victoria Infirmary</i>
Steven	<b>Cook</b>	<i>MBODN</i>
Andrea	<b>Cronshaw</b>	<i>Nottingham University Hospitals</i>
Eva	<b>Danickova</b>	<i>Pinderfields</i>
Roger	<b>Davies</b>	<i>Chelsea and Westminster</i>
Hayley	<b>Dawes</b>	<i>QEHB</i>
Peter	<b>Drew</b>	<i>Welsh Burn Centre</i>
Jennifer	<b>Driver</b>	<i>Birmingham University</i>
Vicky	<b>Dudman</b>	<i>St Andrews Burns Centre</i>
Charles	<b>Edwards</b>	<i>QEHB</i>
Vicky	<b>Edwards</b>	<i>Manchester Adults</i>
Chidi	<b>Ekwobi</b>	<i>The Royal Preston Hospital</i>
Sian	<b>Falder</b>	<i>Alder Hey Children's NHS Foundation Trust</i>
Tony	<b>Fletcher</b>	<i>Nottingham University Hospitals</i>
Brendan	<b>Fogarty</b>	<i>Royal Victoria Hospital</i>
Kirstie	<b>Forbes</b>	<i>QEHB</i>
Emma	<b>Forster</b>	<i>Royal Victoria Infirmary</i>
Charlotte	<b>Gilhooly</b>	<i>Glasgow</i>
Anuraag	<b>Guleria</b>	<i>Manchester Burns Service</i>
Catherine	<b>Hadall</b>	<i>Royal Victoria Infirmary</i>
Kate	<b>Harvey</b>	<i>Welsh Centre for Burns</i>
Tarek	<b>Hassouna</b>	<i>QEHB</i>
Sarah	<b>Hemington-Gorse</b>	<i>Morrison Hospital</i>

Jenny	<b>Hingley</b>	<i>QEHB</i>
Lisa	<b>Hyde</b>	<i>Birmingham Children's Hospital</i>
Louise	<b>Johnson</b>	<i>Royal Victoria Infirmary</i>
Mary	<b>Kennedy</b>	<i>Nottingham University Hospitals</i>
Nadeem	<b>Khwaja</b>	<i>Manchester</i>
Nicole	<b>Lee</b>	<i>St Andrews</i>
Jorge	<b>Leon-Villapalos</b>	<i>Chelsea and Westminster</i>
Darren	<b>Lewis</b>	<i>QEHB</i>
Deborah	<b>Lyne</b>	<i>Birmingham Children's Hospital</i>
Nicola	<b>Mackey</b>	<i>Bristol/SWUK</i>
Heena	<b>Mahmood</b>	<i>Pinderfields Burns Centre</i>
Anirban	<b>Mandal</b>	<i>Whiston Hospital</i>
Naiem	<b>Moiemen</b>	<i>QEHB</i>
Joanne	<b>Moore</b>	<i>Alder Hey Children's NHS Foundation Trust</i>
Michelle	<b>Morris</b>	<i>Northern General Hospital</i>
Joanne	<b>Moysey</b>	<i>QEHB</i>
Randeep	<b>Mullhi</b>	<i>QEHB</i>
Alexandra	<b>Murray</b>	<i>Stoke Mandeville</i>
Preetha	<b>Muthayya</b>	<i>Pinderfields</i>
Nora	<b>Nugent</b>	<i>Queen Victoria Hospital</i>
Sheralyn	<b>O'Hara</b>	<i>QEHB</i>
Claire-Louise	<b>Onions</b>	<i>Welsh Centre for Burns</i>
Jan	<b>Owen</b>	<i>Royal Manchester Children's Hospital</i>
Amy	<b>Pantridge</b>	<i>Stoke Mandeville</i>
Krupali	<b>Patel</b>	<i>QEHB</i>
Lia	<b>Paton</b>	<i>QEHB</i>
Sophie	<b>Pope-Jones</b>	<i>Salisbury</i>
Laura	<b>Presley-Hague</b>	<i>QEHB</i>
David	<b>Ralston</b>	<i>Sheffield Adult and Paediatric Burns Units</i>
Juliette	<b>Rampley</b>	<i>Nottingham University Hospitals</i>
Deborah	<b>Raynor</b>	<i>Nottingham University Hospitals</i>
Michael	<b>Richardson</b>	<i>Pinderfields</i>
Marcia	<b>Roach</b>	<i>Royal Preston</i>
Anthony	<b>Sack</b>	<i>Bristol/SWUK</i>
Pete	<b>Saggers</b>	<i>London / LSEBN</i>
Samar	<b>SALEH</b>	<i>QEHB</i>
Sankhya Kapil	<b>Sen</b>	<i>UHBT/NBT</i>
Sarnaz	<b>Sepehripour</b>	<i>QEHB</i>
Elizabeth	<b>Shale</b>	<i>QEHB</i>
Odhran	<b>Shelley</b>	<i>St James Hospital</i>
Kayvan	<b>Shokrollahi</b>	<i>Mersey Adults, Whiston Hospital</i>
Brendan	<b>Sloan</b>	<i>Pinderfields</i>
Alison	<b>Smith</b>	<i>St Helens &amp; Knowsley Hospitals NHS Trust</i>
Donna	<b>Souter</b>	<i>Manchester Adults</i>
Catherine	<b>Spoors</b>	<i>St Andrews Burns Centre</i>

Lisa	<b>Squires</b>	<i>Royal Victoria Infirmary</i>
Sharon	<b>Standen</b>	<i>North Bristol NHS Trust</i>
Ian	<b>Taggart</b>	<i>Glasgow</i>
Laura	<b>Tasker</b>	<i>QEHB</i>
Eunan	<b>Tiernan</b>	<i>Salisbury</i>
Tomasz	<b>Torlinski</b>	<i>QEHB</i>
Will	<b>Tremlett</b>	<i>Birmingham Children's Hospital</i>
Sanjay	<b>Varma</b>	<i>Northern Regional Burns Centre</i>
Evangelia	<b>Vlachou</b>	<i>QEHB</i>
Tracey	<b>Walker</b>	<i>St Helens &amp; Knowsley Hospitals NHS Trust</i>
Agnes	<b>Watson</b>	<i>St Andrews Burns Centre</i>
Stuart	<b>Watson</b>	<i>Glasgow</i>
David	<b>Wilson</b>	<i>Birmingham Children's Hospital</i>
Yvonne	<b>Wilson</b>	<i>QEHB</i>
Rachel	<b>Wiltshire</b>	<i>St Andrews Burns Centre</i>
Claire	<b>Woods</b>	<i>Royal Victoria Infirmary</i>