Newsletter

Spring 2016 Editor Mike Ankcorn

British Infection Association

The Association Excellence Awards 2016 FINALIST Best Association Newsletter

In this spring issue of the BIA newsletter we bring you the usual reports alongside some interesting articles on a stint within the WHO (Dr Jane Cunningham page 8) and the experience of writing guidelines (Dr Fiona McGill page 4). Both of these highlight the excellent work trainees are doing up and down the country and demonstrate how 'out of programme' experiences can be extremely rewarding. Elsewhere in this issue we hear that times are not easy in this current political climate and a report from Tony Elston on page 3 gives an insight into perceptions of pathology transformation up and down the country.

BIA are thanking outgoing council members who have served BIA so well and will be welcoming new council members very soon - so watch this space for the new additions to the BIA team. For trainees there is an update about NITCAR and we will also be welcoming our new trainee reps soon—both for meetings and also professional affairs.

Don't forget that we have a twitter account now so you can follow BIA on Twitter to keep up to date. Enjoy the Spring meeting.

Mike Ankcorn, Newsletter Editor

twitter

Why not follow BIA on Twitter for convenient and quick updates? @biainfection

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President's Message, Martin Wiselka

I am writing this article as we prepare for the BIA Spring meeting "Infections with a Global Reach". This promises to be an exciting meeting focussing on newly emerging infections, such as zika virus and established infections including HIV and syphilis which continue to affect many millions of people worldwide. The meeting will feature newly recognised infections in exotic locations, cutting edge science and inspirational presentations and these are just some of the reasons why I decided to specialise in infection and continue to be fascinated by the complex interplay between host and pathogen.

I would like to offer special thanks to Professor Stephen Green for organising our meetings. Steve has been the Meetings Secretary for longer than I can remember and combines obvious enthusiasm and knowledge of infection in its broadest sense with a vast network of contacts and the ability to persuade the most inspirational international speakers to support the BIA.

The BIA Spring meeting continues to be provided free of charge and our meetings are supported by the pharmaceutical industry. There are differing views regarding the relationship between professional organisations such as the BIA and Pharma; however the sponsors make a massive contribution to our meetings. They do expect some interest and feedback in return and we will be exploring ideas to increase involvement with the sponsors at the meeting.

The launch of the new training programme in 2015 has, I believe, brought infection specialists together and combined Microbiology/Infectious Diseases is now the most popular training pathway for our newly appointed trainees. Every teaching centre will now have had at least one year's experience of combined infection training and the most successful programmes are those where there is excellent collaboration between departments. I have to mention the success of my local football team, Leicester City, somewhere and their triumph demonstrates the rewards that can be achieved by working together as a team. We recently completed Round 1 of national recruitment for combined infection training and I was extremely impressed with the quality of the trainees and the number of appointable applicants has increased compared to 2015. It is vitally important that we convey our enthusiasm to our students and young doctors to ensure that the most capable consider applying for infection training.

"We recently completed Round 1 of national recruitment for combined infection training and I was extremely impressed with the quality of the trainees."

I am always impressed with the hard work and dedication of the BIA council members and I am encouraged to see that a good number of nominations have been received for the vacant posts on Council. The election results will be announced at the AGM at the Spring meeting. Standing for Council does require time and commitment. However, this is one of the ways that you can shape the specialty for the future. I would like thank all the members of BIA council who are demitting this year. They will undoubtedly be able to put their skills and expertise to good use in future challenges. Peter Cowling has worked particularly hard as Guidelines' secretary and I was delighted to see the revision of the meningitis guidelines which was published in the Journal of Infection earlier this year and is already in use in hospitals across the country. Several other guidelines are in preparation and the BIA plays a vital role in contributing to NICE and Department of Health guidelines and advisory groups.

Looking towards the future, Council has had a number of discussions regarding the best use of the Association's income. The Journal of Infection is one of the main financial contributors to the BIA and I acknowledge the outstanding contribution of Professor Robert Reid as Editor in Chief and the publications team at Elsevier, who have increased the Journal's impact factor year on year, and contributed to its success both scientifically and financially. As a charity we must spend our income according to our stated objectives, but we are also required to set aside funds to cover any future liabilities and expenses. BIA offers a number of high value research grants, develops guidelines and supports several meetings annually. There have been many excellent ideas put forward for intended meetings and workshops. We will be discussing the future focus and spending priorities of the Association at the AGM. I hope that many of you will be able to attend and your input will be invaluable.

Martin Wiselka, President BIA

Manpower & Training Secretary, Bridget Atkins

Training

Recruitment: 2 days of Round one recruitment interviews for Combined Infection Training took place in London in April. The outcome is awaited but there were more applicants (94 for 55-60 posts) to this year than last year. Not all will be appointable and some may decide on alternative specialities or already have ACF posts.

The Combined Infection training programmes commenced in August 2015. There are still separate final CCTs (in MM, MV, ID, TM or dual training, or with General medicine). Transitional arrangement for trainees have now been agreed and published. Trainees will be receiving letters from the college in the near future. The first sitting of the new FRCPath Part 1/CICE exam will be in September 2016. The SCE exam will continue to run for those on the 2010 curriculum.

There are approximately 450 infection trainees in the UK at present, some being microbiology, some virology, some ID, tropical medicine and dual trainees (ID/MM, ID/MV, ID/GIM). Trainees will be mixture of those on the 2010 and 2015 curricula.

LAT posts have now been abolished by the GMC. This may lead to difficulties in filling posts for maternity leave, leavers and for those OOP. Options include appointing local LAS posts, International medical graduates (e.g. through the RCP or RCPath Medical training Initiative) or by the use of Physicians Associates (see below).

Manpower

Consultant Manpower: a Royal College of Physicians man-

power meeting in Nov '15 discussed data showing consultant vacancies in many medical specialities, most apparent in General medicine and Medicine for the Elderly but also present in Infectious Diseases (posts mostly with AGM). Microbiology was not discussed but it is known that many advertised vacancies are unfilled across the country. There are also hidden vacancies which have not been advertised due to lack of eligible candidates. In the meantime there are increased employer/public expectations in fields, many of which span the roles of ID physicians, virologists and microbiologists (e.g. Infection control, antimicrobial stewardship, OPAT, anti viral therapies, device related and other hospital acquired infections, imported fevers, viral haemorrhagic fevers and serious imported respiratory infections).

Pathology modernisation has had an impact on the speciality in some areas. In parallel the career structure for clinical scientists is in development. One of the ways manpower at junior level could be tackled in some areas of medicine is with the use of Physicians Associates. These are described as "providing continuity in a rapidly changing healthcare environment, whilst adaptable to change". They have a 2 year training course after their primary degree and act at foundation doctor level. They are not currently able to prescribe. There are courses now in 9 centres with more planned by the end of 2016.

Bridget Atkins

Clinical Services Secretary, Microbiology & Virology, Tony Elston

The CSC has met in December. The main issues have been pathology transformation, consultant vacancies and training issues.

We have conducted a survey of BIA members on the subject of pathology transformation. On the basis of the feedback from interested responders, the centralisation process has involved the majority of labs (90%). It is perceived as costly and is associated with a failure rate of 15% at this current time, with the majority of these failures taking over 12 months of time/money expenditure to become apparent (70%). Precedent has been set for having an off-site lab given that 47% of responders do not have a lab on site (which will make reversal very difficult in the absence of compelling data) and 36% felt that the issues of having an on-site lab could not be overcome, with the conclusion presumably that there will be a permanent deficit. Of responders, 66% felt that lab centralisation compromised the organisation without microbiology laboratory facilities. The only perceived balance of positivity (considerably/slightly better vs considerably/slight worse) was for cost savings, although a mean of 28% said that pre/post centralisation resulted in the same service. Critically, feedback perceived the process as having been detrimental to specimen turnaround times, quality, infection control, laboratory staff morale and personal job experience. Of responders, 38% said they could provide tangible evidence of the impacts of centralisation. It is not clear from the questionnaire how many centralisation projects are still ongoing and what the appetite is for further mergers/centralisation.

> "We are concerned at the number of consultant vacancies in microbiology/infection posts; a phenomenon that varies across the country"

We are concerned at the number of consultant vacancies in microbiology/infection posts; a phenomenon that varies across the country. We are unsure of the reasons for this but suspect that it may be due to a perception of workload and job satisfaction allied to uncertainty over the future provision of laboratory facilities. The number and quality of clinical queries received by infection teams seems to be increasing and decreasing respectively. There is also some uncertainty as to how this will impact on our collective ability to deliver the new infection curriculum, and whether that will produce doctors able and willing to deliver what is currently expected of Infection Teams.

We are further concerned about the implementation of the new curriculum and the impact of this on the training of infection specialists who will perform those tasks currently undertaken by microbiologists. Colleagues from around the country reported that there is considerable variation in the balance between microbiological and infectious diseases aspects within core training. This is despite clear guidance within the training framework. There is also disquiet that there is insufficient time to train colleagues in those aspects of microbiology that are unlikely to be subsequently delivered by any other group. This could further impact on consultant vacancies and on future provision of infection services like infection control and antimicrobial stewardship.

Tony Elston

Guidelines Secretary, Peter Cowling

"Gone are the days when a small group of volunteers, no matter how expert, can get together, form an ad hoc working party and write guidelines."

The BIA has reached a crossroads in its handling of guideline production.

As I prepare to stand down as Guidelines Secretary, Council needs to consider the future strategy for guidelines.

Gone are the days when a small group of volunteers, no matter how expert, can get together, form an ad hoc working party and write guidelines. The work required is often prohibitive. Certainly, as there is much movement towards NICE accreditation of guideline producers in the United Kingdom, the identification, scrutiny and evaluation of the evidence base is a task that assumes Herculean (if not Sissyphian) proportions. It is also expensive, not least because, if done properly, it requires employment of administrative staff or commissioning of commercial evidence handlers.

The choice is simple but the decision is hard.

BIA could abandon guideline production altogether. This would be a shame because part of our raison d'etre must be to advise our members on matters of recommended, standardised practice.

It could confine itself to small, limited, guidelines commensurate with its capacity to produce them. I believe this would have a deleterious reputational effect on the organisation. Better not to do it at all than to do it half-heartedly.

Finally, it could choose to work in partnership with sister professional organisations and sometimes others, to produce first class guidelines according to the best extant processes. This would be to share the glory and the pain. The partners would change depending on the guideline topic but it should not be forgotten that a number of our infection societies have already invested in permanent resources, including staff, to undertake literature searches and other administrative functions associated with guideline writing.

It is no secret that I prefer the last option. Indeed, we are testing the water by convening a consortium of societies to rewrite the MRSA guidelines. We had a successful telephone conference two days before I wrote this and we are encouraged by the progress that we are making in this partnership venture. If it works, there should be more where that came from.

I wish the BIA well. I am sure that the right decision will be made. I am, however, yesterday's man and, like Lear, 'unburthen'd crawl toward death' whilst my successor, tomorrow's person, takes the helm on guidelines. I wish him/her well also.

Peter Cowling

Memberships Secretary, Dave Partridge

It has been my great pleasure to serve the Association as Membership Secretary over the past 3 years. The new electronic subscription method has been successfully implemented and the website provides us with a platform to further improve the service that we offer to our members in the years ahead. Pleasingly, membership numbers have remained strong despite the inevitable disruption caused by switching payment system and we are gradually seeing an increase in the number of associate members, reflective of our desire to broaden the appeal of the Association to the wider infection community. As ever, we aim to make the society responsive to its members needs and to provide the representation that infection specialists of all types require in challenging times on both micro and macro levels.

I congratulate my successor on their election to the post and wish them every success in achieving this aim.

Dave Partridge

BIA MEMBERSHIP CATEGORY 2016	Active Users
FULL	562
TRAINEE	731
ASSOCIATE	82
RETIRED	21
TOTAL	1396

Writing a guideline – what's involved and should you do it?

When I approached the BIA with the innocent question of 'When are the meningitis guidelines going to be revised?', I should have expected the inevitable response – 'Would you like to do it?'. The honest answer was 'NO!!!' but of course the words that came out of my mouth were something along the lines of 'yes, maybe, why not?'. At the time I was one of the trainee representatives for the BIA and also working as a research fellow with the Liverpool Brain Infections Group, who had recently published the BIA/ABN guidelines on the management of encephalitis. My research was also on meningitis so it all looked like I was in the perfect position to do the job. Three hard years later they have just been published.

> "Publication is only the beginning. The big challenge now is to ensure the guidelines are useful and being used."

So, what was the experience like? One of my colleagues, who had led on the encephalitis guidelines, said the process had nearly killed him – I should have been warned! Actually, although it is hard work I think it is worth it.

The whole process of guideline production involved establishing the writing group, carrying out the literature search and review, co-ordinating several people to write separate sections (and others to review them), putting the whole lot together and re-writing to ensure a coherent writing style, organising review from the stakeholder organisations, submission for publication, responding to peer reviewers comments, launching and publicising the guidelines.

This is clearly quite a task, especially when you are all essentially doing it in your spare time. However, I would say it was worth it and would recommend to others to get involved in the process of national and local guideline production – to see what goes into it. There are difficulties involved in trying to enthuse others, getting things back in a timely fashion etc…. But the benefits of understanding the key literature, collaborating with other experts in the field, understanding the guideline production process and seeing the final product all outweigh the downsides (although it probably won't feel like it at the time!)

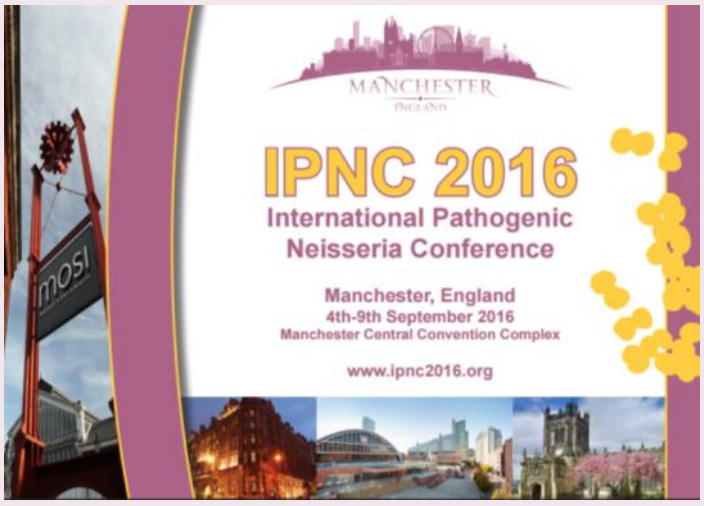
One of the first things that the BIA guidelines secretary said to me was that they were keen for all BIA guidelines to be produced in collaboration with other key stakeholders. Having gone through the process I would say this is absolutely vital – not only to getting the input of other professionals but also in terms of promoting and hopefully implementing the guideline once it is published. Too many guidelines only remain within the specialty producing them. With something like meningitis the vast majority of cases of suspected meningitis and many confirmed cases will primarily be looked after by acute medics, general physicians or intensivists and their input was invaluable. We also involved the Meningitis Research Foundation right from the beginning which not only kept us grounded, reminding us why we are producing guidelines, but they have also helped enormously in producing the algorithm and promoting the guideline throughout the country.

However, publication is only the beginning. The big challenge now is to ensure the guidelines are useful and being used. Implementation of guidelines is a tricky area and involves multiple agencies. I hope the fact that the Society for Acute Medicine, the Intensive Care Society, the Association of British Neurologists and Public Health England were involved will help. I also hope the BIA members will do their utmost to promote them amongst their non-infection colleagues. As well as implementation there should also be an assessment of the impact of the guidelines – an area which is rarely done and poorly researched.

Finally, whilst it is not always appropriate for a trainee to be the lead on guideline committees (and I couldn't have done it without the support of Prof Rob Heyderman and Prof Tom Solomon) I know some organisations, such as BHIVA, actively encourage trainees to be part of their guideline committees. I hope the BIA and others will consider doing the same.

Fiona McGill,

Brain Infections Group, Institute of Infection and Global Health, University of Liverpool



To read the up to date UK guidelines for meningitis visit

http://www.journalofinfection.com/article/S0163-4453(16)00024-4/fulltext

JOURNAL OF INFECTION

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Editor in Chief, Robert Read

JOI Most requested articles of those published in the past 6 months (Sept 2015- to Feb 2016)

Article Title	Author(s)	Vol	Issue	Paper Type	Cover Date	Online Date	Requests for articles
MRSA colonization and the nasal microbiome in adults at high risk of colonization and infection	Bessesen, M.T.; Kotter, C.V.; Wagner, B.D.; Adams, J.C. et al	71	6	Full length article	01-Dec-2015	2015-09-01	928
Infectious disease consultation for Staphylococcus aureus bacteremia - A systematic review and meta-analysis	Vogel, M.; Schmitz, R.P.H.; Hagel, S.; Pletz, M.W. et al	72	1	Full length article	01-Jan-2016	2015-10-09	780
Utility of immune response-derived biomarkers in the differential diagnosis of in-	ten Oever, J.; Netea, M.G.; Kullberg, B.J.	72	1	Review article	01-Jan-2016	2015-09-30	734
Recent advances in pathophysiology and biomarkers of sepsis-induced acute kidney injury	Umbro, I.; Gentile, G.; Tinti, F.; Muiesan, P.; Mitterhofer, A.P.	72	2	Review article	01-Feb-2016	2015-12-15	681
The introduction of the meningococcal B (MenB) vaccine (Bexsero^(R)) into the national infant immunisation programme - New challenges for public health	Ladhani, S.N.; Campbell, H.; Parikh, S.R.; Saliba, V.; Borrow, R.; Ramsay, M.	71	6	Review article	01-Dec-2015	2015-10-02	664
Extra-intestinal pathogenic Escherichia coli (ExPEC): Disease, carriage and clones	Dale, A.P.; Woodford, N.	71	6	Review article	01-Dec-2015	2015-09-26	579
Impact of antifungal prescription on relative distribution and susceptibility of Candida spp. - Trends over 10 years	Bailly, S.; Maubon, D.; Fournier, P.; Pelloux, H. et al	72	1	Full length article	01-Jan-2016	2015-10-28	544
Comprehensive clinical and epidemiological assessment of colonisation and infection due to carbapenemase-producing Enterobacteri-	GEIH-GEMARA (SEIMC) and REIPI Group for CPE; Palacios-Baena, Z.R.; Oteo,	72	2	Full length article	01-Feb-2016	2015-11-04	502
The UK joint specialist societies guideline on the diagnosis and management of acute meningitis and meningococcal sepsis in immuno-	McGill, F.; Heyderman, R.S.; Michael, B.D.; Defres, S. et al	72	4	Full length article	01-Apr-2016	2016-02-02	486
The epidemiological characteristics and genetic diversity of dengue virus during the third largest historical outbreak of dengue in Guangdong, China, in 2014	Sun, J.; Wu, D.; Zhou, H.; Zhang, H.; Guan, D.; He, X.; Cai, S.; Lin, J.	72	1	Full length article	01-Jan-2016	2015-11-10	460

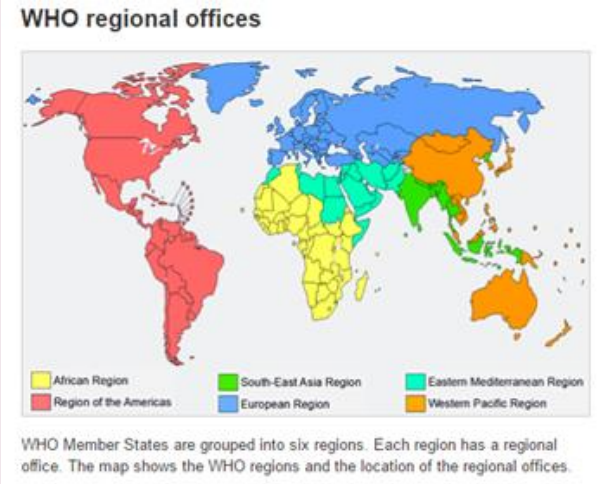
JOURNAL OF INFECTION

Article Title	Published	Altmetric Score	Where it was mentioned in the last 6 months
The UK Joint Specialist Societies Guideline on the Diagnosis and Management of Acute Meningitis and Meningococcal Sepsis in Immunocompetent Adults	Feb 2016		Picked up by **1** news outlet(s) Tweeted by **74** On **1** Facebook page(s) **7** readers on Mendeley
Zika fever and congenital Zika syndrome: An unexpected emerging arboviral disease?	Feb 2016		Blogged by **1** Tweeted by **28** Referenced in **2** Wikipedia pages **41** readers on Mendeley
Vibrio vulnificus and V. parahaemolyticus necrotising fasciitis in fishermen visiting an estuarine tropical northern Australian location	Jan 2007		Picked up by **1** news outlet(s) Blogged by **1** **7** readers on Mendeley
Increasing incidence of necrotizing fasciitis in New Zealand: A nationwide study over the period 1990 to 2006	Dec 2011		Picked up by **1** news outlet(s) Blogged by **1** **15** readers on Mendeley
Pharyngeal carriage of Neisseria species in the African meningitis belt	March 2016		Blogged by **1** Tweeted by **2** **2** readers on Mendeley
Symptoms seem to be mild in children infected with avian influenza A (H5N6) and other subtypes.	Sept 2015		Blogged by **1** Tweeted by **2** On **1** Facebook page(s)
Antibiotics versus placebo in the treatment of women with uncomplicated cystitis: A meta-analysis of randomized controlled trials	Jan 2009		Picked up by **1** news outlet(s) **6** readers on Mendeley
Respiratory viruses seasonality in children under five years of age in Buenos Aires, ArgentinaA five-year analysis	Jan 2004		Picked up by **1** news outlet(s) **22** readers on Mendeley

OUTBREAK at the World Health Organisation, Geneva……..

As a joint Infectious Diseases and Microbiology Specialty Registrar in the Yorkshire and Humber deanery I have recently had the amazing opportunity to complete a Public Health rotation at the World Health Organisation (WHO) in Geneva. Between November 2015 and February 2016 I spent time working with the Global surveillance and risk assessment (RAS) team, more commonly known as "Outbreak."

You're sitting at your desk compiling data on a cholera outbreak but another story keeps trending on several media platforms. "Brazil's surge in small-headed babies." How can you identify whether this is a genuine concern requiring escalation of Public Health measures or something that can be safely discarded? Put succinctly, how does the global health infrastructure work ?



WHO Member States are grouped into six regions. Each region has a regional office. The map shows the WHO regions and the location of the regional offices.

The WHO evolved following the establishment of the United Nations in 1948 "for the purpose of co-operation among themselves and with others to promote and protect the health of all peoples." This is a broad remit and given the diversity of the populations it serves, no small task.

The role of "Outbreak" is to monitor and implement public health policies and programmes in the areas of surveillance and response to public health emergencies. This includes emerging and re-emerging infectious diseases with a particular focus on those with epidemic and pandemic potential.

The worldwide inequality of healthcare systems means that the effective diagnosis and treatment of many infectious diseases remains challenging in large parts of the world. The evolution of XDR Mycobacterium tuberculosis and carbapenemase resistant gram negatives are examples of urgent international challenges for antimicrobial stewardship and epidemiological control of infectious diseases. Not only can these pathogens impact on local populations but the global potential for transmission has been highlighted by recent events in West Africa.

Information regarding outbreaks is obtained by the team through multiple channels. Formal notification to the WHO regarding an outbreak should be performed by member states when a public health threat achieves at least two of the four criteria outlined in the International Health Regulations 2005. These are;

- whether the event is deemed serious,
- whether the event is unusual or unexpected,
- whether there is a significant risk of international spread and,
- whether there is a significant risk of international travel or trade restrictions.

Media monitoring and informal networks also contribute to information gathering.

When events are deemed of significant concern, epidemiological data is requested from the member state or states via their national focal point (NFP). The WHO currently operates on a three level hierarchy with headquarters in Geneva working as a central hub. The subsequent tiers include the regional and country offices. Information is cascaded within WHO and, when requested by member states, assistance is offered via the GOARN (global outbreak and response network) mechanism. This can take many forms including laboratory support, epidemiological in-put or clinical support. Many BIA members will have received requests for assistance cascaded through this mechanism.

The task of the outbreak team is formidable. Imagine the challenges of trying to risk assess such a vast amount of information in a huge diversity of languages, across multiple time zones and in locations with differing public health infrastructures and capacities. Transparency and diplomacy are essential and a constant balance has to be struck between the interests of the member state reporting an outbreak and other areas at risk.

This was an excellent opportunity for me to observe first-hand the challenges faced in managing outbreak situations. As well as the technical expertise needed to give appropriate clinical advice, the team also has to strike the delicate balance of when to publicly declare problems which may have significant consequences for tourism, trade and travel for member states. I learned a great deal from working with such a dedicated team. As the world shrinks and pathogens can literally fly around the world in hours, the challenges of international disease control expand. Only a truly global collaborative approach will be effective.

Acknowledgements

I would like to thank all members of the WHO outbreak team who made my time so rewarding and also my Sheffield based supervisors for supporting me in taking up this wonderful opportunity.

Jane Cunningham, ID/Microbiology StR, Sheffield

Training Day Reviews: HIV Dilemmas

The BIA Workshop in Infectious Diseases: HIV dilemmas held in Manchester took place in January 2016. It was the 9th year this program was run and again was a great success.

The lectures always centre around real-life, challenging cases presented by experts in the field at a level suitable for both consultants and trainees across all specialties who manage patients with HIV. The speakers encourage the audience to participate and interactive key-pad voting is used for all lectures, meaning that delegates can become involved without ever feeling put on the spot and there is ample opportunity to ask questions. There is always excellent banter between the lecturers keeping the audience entertained and engaged.

The topics vary each year and areas that were covered this time included; HIV infection in pregnancy, co-infection with TB and Hepatitis, pyrexia of unknown origin in HIV patients, challenging opportunistic infections and problematic aspects of anti-retroviral medication such as drug resistance and interactions. As always the lectures were very clinically focused covering practical aspects of management such as what investigations to order, how to interpret results and treatment options. One of the most engaging lectures focused on ethical conundrums faced when managing complex patients with HIV and prompted much thoughtful discussion and reflection.

At the end of the course delegates got a CPD certificate – always useful for portfolios and revalidation. It was a thoroughly enjoyable, educational day and I would recommend it to anyone managing patients with HIV.

Christina Petridou

ID/Microbiology StR, Hampshire NHS Trust

BIA Award: From Clinical Exchange to Clinical Research Fellow

I am a paediatric registrar (ST4) in the North West with a long-standing passion for neurological infectious diseases. At the start of my junior doctor years, I successfully obtained an academic foundation post within the Liverpool Brain Infections Group at the University of Liverpool, led By Professor Tom Solomon. I ran a small research project evaluating coma scales in Nepali children with encephalopathy. The project motivated my interest in tropical and resource poor medicine. I was exposed to a high clinical burden of children with impaired consciousness due to a wide variety of brain infections. Children were encephalopathic with features of dehydration and raised intracranial pressure, and there was limited intensive care support. I observed vastly different management practices, particularly regarding fluid resuscitation. This sparked my focus on paediatric non-traumatic encephalopathies. Wanting to build on this area of interest, I successfully obtained an academic clinical fellowship (ACF) in paediatric neurological infectious diseases within the same research group.

At the beginning of my ACF, in May 2014, I successfully applied for the British Infection Association 'Clinical Exchange' grant. This funding supported my travel to The National Institute of Mental Health and Neurosciences in Bangalore, India. This time allowed me to assess the feasibility of running a study entitled "Non-Invasive Monitoring of Brain Intra-cranial pressure and cerebral oxygenation in encephalopathic children (NIMBI)". The study aims to utilise non-invasive tools to more closely monitor intracranial pressure and cerebral oxygenation, with future potential to better guide treatment of acute encephalopathy. The Clinical Exchange grant allowed me to establish a formal collaboration with medical device companies for 'The Cerebral and Fluid Cochlear Pressure Analyser' and 'Near Infrared Spectroscopy' to optimise parameter measurements. This feasibility work has identified that these non-invasive tools are easy to use and applicable to the resource poor setting to study paediatric encephalopathy. This work has led to me very recently successfully applying for The Wellcome Trust Clinical Research Fellowship 'Health priorities in the resource limited setting' at the University of Liverpool and Liverpool School of Tropical Medicine. I relish the opportunity to build on my bedside and laboratory skills and broaden my tropical infectious diseases knowledge under the structured taught first year MRes of the programme. Thereafter, I will undertake a PhD enhancing child health in resource poor settings. I hope to conduct a project that will go some way to improving the understanding and management of paediatric encephalopathy due to infections. I am sincerely grateful to the BIA for supporting my initial work that has led to me being accepted onto this prestigious fellowship.

Stephen Ray

Brain Infections Group, Institute of Infection and Global Health, University of Liverpool

Trainees' Page

Professional affairs trainee representative & ID SAC trainee representative. Joby Cole

The ID SAC and CIT SAC were postponed until April due to the industrial action. At both meetings the trainees raised concerns related to the imposition of new junior doctor contracts and the likely impact this would have on training and time spent in specialty. The committees were sympathetic, shared our concerns and agreed to write a letter to the head of the Royal College showing their support for trainees and outlining these concerns.

The current guidance on transition from the old curriculum to the 2014 curriculum were reiterated and are available on the RCPath and JRCPTB websites, including contact details if more information is required.

The current trainee representatives at SAC will rotate over at the next meeting in June.

Joby Cole

National Infection Trainee Collaborative for Audit and Research (NITCAR)

NITCAR Update - April 2016

Following our second annual meeting in February, NITCAR has continued to grow. Several new projects were agreed upon for the forthcoming year and details can be found in our first newsletter. We are keen to get as many infection trainees as possible involved, so please get in touch by email (chair@nitcollaborative.org.uk) or via our website (www.nitcollaborative.org.uk) if you would like to be involved in any of our projects, propose a project of your own or just be kept up to date with NITCAR's progress.

NITCAR Annual Meetings

The next annual meeting will take place in Leeds on 16th March 2017.

A big thanks from BIA to the outgoing trainee reps

BIA would like to thank Joby Cole, Rajeka Lazarus & Maheshi Ramasamy for all the hard work and enthusiasm they put into their roles as BIA training representatives. You will be missed from your roles. We will be introducing our new trainee reps soon!

HIS Update

There are two events organised by the healthcare infection society (HIS) relevant for trainees:

1) 4th July – Free HIS training day (Birmingham) - Infection Prevention and Control in Non-Acute Settings

https://www.his.org.uk/education/trainee-education-programme/

2) HIS small research grant (up to £10,000) - To support small-scale research projects - deadline 31st July

http://www.his.org.uk/awards/small-research-grants/#.VwTciZwrKig

Also don't forget about **FIS/HIS 2016** talking place between 6-8 November 2016, EICC, Edinburgh.

The Federation of Infection Societies (FIS) Annual Conference and the 10th Healthcare Infection Society (HIS) International Conference will take place at the Edinburgh International Conference Centre.

FIS/HIS 2016 provides a unique forum for healthcare professionals working on the prevention and control of healthcare-associated infections to unite. The Conference will facilitate the sharing of research and allow for delegates to learn about the latest developments within this rapidly expanding and changing field.

This three-day scientific conference is a collaboration between all the member societies of FIS who share an interest in infection in its broadest sense. The conference is run in conjunction with the biennial Healthcare Infection Society International Conference and is hosted by HIS.

Key dates:

Friday 24 June: abstract submission deadline

Early August: confirmation of accepted abstracts

Friday 5 August: bursary submission deadline

Friday 9 September: early bird registration deadline

Sunday 6 November: conference opens

Events calendar

Meeting	Date and Location
May	
BSAC 2016 Roundtable Series on Antimicrobial Resistance	19 May 2016, London
June	
The Infection Prevention Society (IPS) North East branch	08 June 2016, Newcastle
RCPE Symposium: Infectious Diseases	08 June 2016, Edinburgh
TB Summit 2016	21-23 June 2016, London
ISPPD 2016 -10th International Symposium on Pneumococci & Pneumococcal Diseases	26-30 June 2016, Glasgow
July	
The Future of Infection Prevention and Control Conference (London)	07 July 2016, London
Hot Topics In Infection And Immunity In Children – The ESPID-Oxford Course	11-13 July 2016, Oxford
August	
Oxford Bone Infection Conference	31st August 2016, Oxford
September	
35th Annual Meeting of the European Bone and Joint Infection Society	1-3 September 2016, Oxford 04-09 September 2016, Manchester
RCPath day—Managing Intracranial Infections	23 September, London

Events calendar

Meeting	Date and Location
September	
Infection Prevention 2016	26-28 September 2016, Harrogate
Molecular Biology and Pathogenesis of Avian Viruses	27-29 September 2016, London
October	
National Infection Training Days at RCPath	19-20 October 2016, London
November	
FIS/HIS 2016	06-08 November 2016, Edinburgh
December	
BIA Autumn 2016 Trainees' Meeting	01 December 2016, Manchester

OXFORD BONE INFECTION CONFERENCE

31st August 2016

Oxford Town Hall, Oxford