Welcome

Welcome to the July edition of NewWave.

If you have any relevant articles or papers that you would like to be included in future editions, please email them to steve.perring@poole.nhs.uk

In Memoriam

AGIP Council mourns the untimely death of Graeme Duthie, previous President of AGIP

A full obituary of Graeme will be included in the next edition of NewWave

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Forthcoming Events 2018:

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<td>17-18 October 2018</td>
<td>3rd London Masterclass</td>
<td>Dental Institute, Royal London Hospital, London</td>
<td>Details from <a href="mailto:rachel@ardmorehealthcare.com">rachel@ardmorehealthcare.com</a>.</td>
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<tr>
<td>19th November 2018</td>
<td>BSG Oesophageal Section Education Symposium</td>
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<td>1st March 2019</td>
<td>AGIP Masterclass in Upper GI Physiology</td>
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<td>18-21 May 2019</td>
<td>Digestive Diseases Week</td>
<td>San Diego Convention Center San Diego, CA</td>
<td><a href="http://www.ddw.org/home">http://www.ddw.org/home</a></td>
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<td>17-20th June</td>
<td>BSG Annual Meeting</td>
<td>Glasgow</td>
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Happy 70th Anniversary to the NHS
3rd LONDON MASTERCLASS:
CONTEMPORARY MANAGEMENT OF CONSTIPATION

Date and time
October 17th & 18th, 2018

Location
Bearsted Lecture theatre, Alexandra Wing, Dental Institute Royal London Hospital, Whitechapel, London, UK

Goal
Chronic constipation remains an enormous clinical and scientific challenge. It is 9 years since we hosted the last major meeting devoted to this subject, and hence, by way of update, we have again assembled an International Faculty of recognised experts, each of whom command a body of work in this field, and who continue to publish contemporary studies. The goal of this meeting will be to disseminate and to critically appraise both a contemporary understanding of current best clinical practice, but also to highlight those evolving concepts relevant to this condition that hopefully will lead to improved management in the future.

Target audience
Gastroenterologists, pelvic floor surgeons, urogynaecologists and paediatricians at Consultant and trainee level, clinical physiologists, clinical research fellows, specialist nurses, dieticians and nutritionists.

Course highlights:
- Sessions on:
  - Clinical burden and aetiology
  - Key clinical associations
    - Pathophysiological mechanisms
  - Diagnostic testing
  - Therapeutic options (behavioural, medical and surgical)
- Keynote lectures on: colonic motor dysfunction; whether chronic constipation and IBS-C truly represent separate entities; gut microbiota and probiotics; the future of medical therapies
- Panel discussion: when to test, which test, and what does it mean?
- Panel discussion: bringing it all together. The management algorithm.

Cost
Masterclass: October 17th & 18th
£ 200.00 for Consultants
£ 50.00 for Trainees, nurses, clinical physiologists, dieticians and nutritionists.

Registration
Please telephone Rachel Broome on +44 (0) 1494 721820
or e-mail rachel@ardmorehealthcare.com

Course Organizers

Dr Mark Scott
Senior Clinical Scientist

Prof Charles Knowles
Clinical Professor

Miss Emma Carrington
Lecturer in Colorectal Surgery

Queen Mary
University of London

Ardmore Healthcare

Laborie

MMS Medical Measurement Systems
The meeting was held at the Washington convention centre and was attended by just over 14,000 people. The four day conference featured 4,110 posters, 981 presentations by invited speakers and 1,100 oral abstracts (according to their blog). The topics were comprehensive covering each aspect of both luminal GI and hepatology. There was a large exhibition hall with many companies promoting their products. The AGA had a learning zone which I utilised. there were interesting short lecture slides on various pathologies explaining how the disease is diagnosed and the endoscopic and surgical treatments used. I watched a video on the radiofrequency treatment of Barrett's and endoscopic treatments for achalasia.

I attended a meet the Professor luncheon with prof Jan Tack who discussed the latest research and treatments for functional dyspepsia. I didn't write about this as it wasn't really physiology based but is an area of interest for me. I attend our trusts upper benign diseases MDT where difficult cases are discussed and often these patients are labelled as "gastroparesis". The session was very inspiring and thought provoking for contemplating taking up research in this area in the future.

Having just acquired a high resolution oesophageal manometry system at the beginning of the year I was grateful to have the opportunity to attend a meet the Professor lunchtime session entitled “Esophageal manometry: How to Interpret and how to manage”. Professor John Pandolfino and Dr J Clark presented the session. Case studies were used to provide tips and reminders regarding how to interpret studies and the importance of the clinical story. Professor Pandolfino discussed protocols used in his laboratory including one used for patients with rumination/ belching syndrome. Following the conventional protocol patients are asked to eat a snack/food that brings on their symptoms that they have taken from home. The recording continues for 20 seconds after ingestion to observe the response and documenting symptoms as they occur. A post prandial protocol is also used for dysphagia cases where the conventional tracing does not yield a diagnosis. Following 5 swallows with the patient’s food the recording period is extended to a lengthy 30 minutes after ingestion of a provocative meal. It was noted that this time period may be useful in the rumination population if the shorter time frame was negative.
Professor Sifrim presented a lecture on the new upper GI diagnostic tools available. Alas there are none ready for clinical use! However, he did discuss several of the posters and topics that had been covered in previous sessions. Two metrics seem to have been the hot topic of research over the last few years-mean nocturnal baseline impedance (MNBI) and post swallow peristaltic wave (PSPW) index. Dr Cai had given a presentation on her work regarding the theory that MNBI correlates with abnormal pharyngeal reflux in patients with suspected LPR symptoms. Measurement we taken from hypopharyngeal and oesophageal impedance-pH measurements using a specialised catheter. Two or more events at the hypopharynx were considered abnormal. Distal MNBI was noted to be significantly lower in patient with abnormal pharyngeal reflux (1938 Ohms v 2460 Ohms p=0.003). The cut-off for defining low was 2292 Ohms. The author indicated that this matrix had been used by Caroll et al to demonstrate that patients with LPR symptoms refractory to PPI could be selected for anti-reflux surgery using this technology and that it could predict response. The numbers in the study were small but along with talks of MNBI in other research relating to lung transplantation suggests that this will likely be a future development that will translate into clinical investigation.

Post swallow peristaltic wave (PSPW) index was also a focus of interest in several presentations. This was originally defined by Franzzoni et al as “as antegrade 50% drop in impedance to the pre swallow baseline originating in the most proximal impedance sites, reaching all the distal impedance sites and followed by at least 50% return to baseline in all impedance sites (bolus exit). The cut-off appears to be 61% and studies have shown that a low PSPW index is associated with erosive reflux disease, Barrett’s oesophagus and dysplasia that progresses to Barrett’s. The paper given by Dr Rangan investigated whether MNBI and PSPW could be used to predict decline in lung function in pulmonary fibrosis. The work demonstrated that lower distal MNBI, proximal MNBI and PSPW index on MII-pH correlated with worse decline in the first year after transplant.

Professor Sifrim also discussed the need to revisit the AED threshold. This work builds on the revision of the Lyon consensus. It was put forward that grade A/B oesophagitis, a total of reflux events between 40-80 and an AED of 4-6% was in a so called “grey area” where the diagnosis of GORD was borderline or inconclusive. Therefore, there was a need for adjunctive tests that could strengthen the diagnosis. MNBI was looked at to try and determine whether this metric would be able to achieve this. The study found that patients with a low MNBI showed inconsistent response to antireflux treatment.

There was discussion regarding the functional luminal imaging probes (FLIP) device. This device measures the OGJ distendibility and can be used to identify hiatal hernia, measure distendibility of the GOJ and crural diaphragm. A device that can measure transphincteric pressure index using a bear down manoeuvre to evaluate the continence of the OGJ in patients with GORD was also presented.

I attended a “Best of UEGW” session on functional disease where the focus of the session was on belching disorders. The normal frequency of belching was defined as 10-20 per day but can increase dramatically to >1000 in belching disorders. It is known that this is commonly associated with reflux disease or functional dyspepsia and that it has few treatment options. The mechanism of supragastric belching was discussed. Negative pressure is drawn into the oesophagus to contraction of the diaphragm and relaxation of the UOS. This fills the oesophagus with air while the LOS remains closed. The pressure increases in the oesophagus and is followed by a belch. This is demonstrated on impedance-pH.

A paper of Professor Sifrim’s group was presented that looked at the effect of CBT on reduction of supragastric belching. Patients were taught warning signs and given preventative exercises. MII-pH was performed before and after the treatment. It was found that the patients self-assessed a reduction in severity of around 50%, the number of documented belching episodes
decreased by around 50% and the acid exposure decreased by around a third. I found this presentation very interesting and thought provoking. Not only did it provide ideas for future research it highlighted possible new clinical tools and metrics that may be able to improve diagnosis as well as highlighting the possibility of the use of impedance-pH in assessment of new treatments in cases of belching disorders.

Washington DC is a lovely city and was particularly hot at the beginning of June. On the day after the conference I took the opportunity to attend some of the local attractions such as the Lincoln memorial, reflecting pool, Washington monument and war memorials.

In 2013 I set up a sphincter of Oddi manometry service with Dr John Leeds, who had a specialist interest in sphincter of Oddi dysfunction. In 2015 we conducted an audit of the short-term outcome and safety of the procedure which was presented at DDF. The data presented at DDW this year concerned medium term outcomes as I was keen to look at whether the good outcomes we had seen in short term had persisted into medium term. The abstract was well received and invited many questions.

**Outcome of Endoscopic Sphincterotomy in Biliary Manometry Confirmed Sphincter of Oddi Dysfunction Type 2 Patients: A Medium-Term Follow-Up**

V Ritchie, J Leeds and U Basavaraju

**Introduction:**
Persistent biliary pain following cholecystectomy can be a challenging symptom to manage and the role of sphincterotomy has been questioned. Manometry during Endoscopic RetrogradeCholangiopancreatography (ERCP) has been available in our unit since 2013 for patients with suspected type II sphincter of Oddi dysfunction (SOD). There is little data in the literature regarding the medium-term outcome for patients undergoing this procedure. However, it is suggested that patients who receive manometry guided sphincterotomy benefit most from the treatment. The aim of this audit was to determine whether their outcomes at medium term were different from their short-term outcomes.

**Methods:**
Patients who had undergone manometry guided sphincterotomy more than three years ago for symptoms relating to sphincter of Oddi dysfunction type 2 and who had been reviewed in the short-term were assessed. Review was conducted by means of medical notes review or phone call to determine the patient’s perspective of improvement in pain and satisfaction with the treatment. Scores allocated were as follows: 1: Asymptomatic, 2: Experiencing some symptoms but signifi-
cant improvement and satisfied with outcome, 3: Experiencing symptoms and dissatisfied with outcome, 4: No change in symptoms and dissatisfied with outcome.

Results:
19/20 patients underwent sphincterotomy. One patient could not be followed up in the short term and was excluded from the analysis. Of the remaining 18 patients, the mean age was 43 years and were predominantly female (n=16). 4/20 had acute pancreatitis post ERCP (3 mild, 1 moderate). There were no patients that scored a 4 at short-term. Thirteen patients were available for medium-term follow-up.

<table>
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<th>Outcome score</th>
<th>Medium-term score 1</th>
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<th>Medium-term score 3</th>
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<td>5</td>
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<td>1</td>
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Table 1 Medium term outcomes in relation to short term scores

In the short-term, patients had been followed-up at a mean of 17 weeks with the majority of patients finding benefit post sphincterotomy. 70% of patients reported a score of either 1 or 2 at short-term follow-up. The mean duration of medium term follow-up was 44 months. There were no patients that remained asymptomatic. However, the majority of patients followed up were still significantly improved and happy with their outcome with a score of 2 (71%). All of the patients scoring a 2 remained at this level at medium-term. Of the 10 patients in the favourable result group followed up (score 1 or 2), only 2 moved into an unsatisfactory outcome at medium-term (both scored 4) A larger cohort would be needed to assess outcome trends in more detail and it is acknowledged that five patients were lost to follow-up.

Conclusion:
Our results indicate that patients who have undergone manometry guided sphincterotomy for symptoms related to sphincter of Oddi dysfunction type 2 remain significantly improved in the medium-term.
This insightful presentation began by highlighting the use of cardiac imagery and the advances it provides in medicine. An example of aortic stenosis was shown and the imagery provided allowed for a clear evaluation of the heart’s anatomy and function. Dr Menys stated that the images portray “a decade of hard work within medical physics” and that magnetic resonance imaging (MRI) can be used as a substitute for computerized tomography (CT) imagery in assessing the anatomy of the gastroenterological system.

A case study regarding motility in Crohn’s disease was then discussed. All imagery used was sourced from radiologists studying Crohn’s disease and by using MRI; the evolution of motility can be assessed prior to anti-tumour necrosis factor (TNF) therapy and post TNF therapy. TNF is a protein that is over-active in the body in those who have inflammation. By using MRI analysis, it allows for quantitative data to be processed and deformation fields to be generated. With these values, a “colour map” can be created in order to identify areas of good motility and regions with a lack of motility.

Dr Menys then went on to present a set of retrospective and multi-centre studies. He found that the performance of motility correlated positively with the magnetic resonance index of activity (MaRIA).

In relation to TNF therapy, Dr Menys stated that a motility difference can be identified within “a matter of months” and the values collected from patients studied a year after beginning the TNF therapy was enough evidence to achieve funding from the National Institute for Health Research (NIHR) to study 140 patients pre, mid and post therapy.
A timeline in relation to Crohn’s was then shown:

- 2010 – Motility described as marker of CD (Froehlich et al 2010)
- 2012 – Motility as a biomarker of Inflammation (Menys et al 2012, Cullman et al 2013)
- 2015 - Prospective repetition of TI motility (Menys et al 2015)
- 2015 – Motility as predictor of response (Plumb et al 2015)
- 2017 – EME trial ‘MOTILITY’ (Taylor & Plumb) *currently running*
- 2018 – CE Marking of motility analysis (GIQuant)

Within eight years, the above research and information has been undertaken and published which is considered to be a fundamental reason for this form of imagery within GI investigations.

Further application in terms of symptoms and new methods were then discussed. Initially Chronic Intestinal Pseudo-obstruction (CIPO) was discussed, with MRI case studies showing how this is identified. Dr Menys then went on to present MRI case studies of both asymptomatic and symptomatic patients with Crohn’s disease, collating data from 46 patients. Dr Menys found that the more homogeneous the activity in the bowel, the more symptomatic the patient was and an elegant slide was shown to demonstrate this:

Limitations were then discussed. Dr Menys explained that the colon was a difficult region to monitor using an MRI due to the infrequency in movement. He therefore suggested that prior preparations should be considered to stimulate the colon. MRI studies have the ability to measure motility, transit time and the contents of the colon.

Magnetic Resonance (MR) Manometry studies are currently being undertaken by the Nottingham Digestive Diseases Biomedical Research Centre, known as the ‘RECLAIM study’, on 150+ patients who suffer with constipation.

Finally, with regards to the stomach and dyspepsia a previous study has been undertaken by Dr Menys and his team consisting of 9 Ehlers Danlos patients suffering with dyspepsia and 9 healthy age/sex/BMI matched patients. The study measures motility, emptying and accommodation through the use of MRI. Dr Menys explained that a simple protocol is to be in place when
undertaking studies of this nature, ensuring that patients have multiple periods of rest throughout the study and have scans intermittently. This allows for the study to be more tolerable for the patient. Water is provided to patients and at regular intervals the patient is scanned in order to identify the motility, emptying and accommodation of the stomach.

In summary, Dr Menys stated that MR imaging can be used as a substitute for computerised tomography imagery in the assessing of the gastroenterological system. More research needs to be undertaken and for those who wish to pursue this, funding and industry partners are actively searching for new ideas. This discussion was very informative and provided a clear insight into the different methodology available with regards to the use of MRI in assessing gastrointestinal disorders.

Gastric and small bowel motility – reaching the parts others can’t reach

Presentation by Dr Adam Farmer (N Staffs and Loyal London)
Samantha Hewitt (Hull & East Yorkshire Hospitals)

This interesting presentation by Dr Adam Farmer began by giving a brief summary on the complicated enteric nervous system. An Informative image provided a clear view of the layers of the GI Tract. Dr Farmer elaborated on the enteric nervous system and its heterogeneity similar to that of the central nervous system and went on to mention the autonomic nervous system, focusing briefly on the parasympathetic nervous system, particularly the vagal nerve and its interaction in terms of mediating both hunger and motility.
So, what happens when it all goes wrong? Any structural or functional abnormality at any level of that brain gut axis can lead to changes in perception and reflex control of GI tract motility and this in itself may lead to symptoms of visceral hypersensitivity.

Dr Farmer asked why we should measure motility. He explained that whether motility is accelerated normal or slow this can’t be adequately measured by using symptoms alone. These disorders exert a significant impairment on people’s quality of life and also cause considerable health care expense, across the leading 8 health care economies worldwide these disorders cost in the order of 42 billion dollars per annum.

So what is an ideal test? According to Dr Farmer it should be:

- on-invasive
- Widely available and convenient for the patient
- Have a degree of reliability.
- It should be able to assess the GI tract in the fasting and post prandial state
- Should be able to differentiate food, secretion and air within the lumen of the GI tract
- Use provocative measures to try and stimulate and reproduce symptoms.
- Cover much of the gut

He emphasised that Endoscopy should be performed prior to assessment of motility to exclude a structural abnormality or mucosal lesions.

Motility testing can be useful in a targeted group of patients, particularly those who have reflux disease that are not responsive to standard antisecretory therapy, when thinking about doing antireflux surgery on a patient, people who are having bariatric surgery etc.

He then moved on to discuss different ways to test motility.

**Scintigraphy**

Gastric emptying scintigraphy is considered the gold standard for measuring gastric emptying. Patients come in fasted and they have a meal of a low calorific content labelled with 99Tc with imaging at 0, 1, 2 and 4 hours post ingestion of the meal, to assess emptying of solids. The one hour scan is used to detect rapid gastric emptying with percentage retention of <30%. The 2 and 4 hour scans are then used to detect delayed gastric emptying with retention of >60% or >10% at 2 and 4 hours respectively.

Small bowel scintigraphy similarly assesses transit of a test meal through the small bowel. However this test is not widely performed outside of the US and is rare in the UK.

**Manometry**

Antro-duodenal manometry is useful when you suspect small intestinal pseudo-obstruction. It can reasonably differentiate between a neuropathic cause and a myopathic cause. It measures the presence and propagation and duration of the three migrating motor complex phases during the fasting and postprandial state. The position of the catheter is important when placing to obtain reliable measurements. However, it is of limited availability as not many centres across the UK
Update on the North American consensus group guidelines for hydrogen and methane breath testing
Presentation by Anthony Hobson
Reviewed by Steve Perring
Poole Hospital

Anthony started his talk by suggesting that breath testing (BT) is essentially a provocation test for the bowel.

The large bowel is heavily populated by bacteria that are symbiotic with their host. It is estimated that 10-15% of the calorific value of foodstuffs we eat are derived from the by-products of fermentation by these bacteria in the large bowel. However, the small bowel should be largely free of colonisation by bacteria. Small intestinal bacterial overgrowth (SIBO) is where the small bowel is inappropriately colonised by bacteria. The symptoms accompanying SIBO have considerable overlap with reflux disease, but generally include bloating which does not improve with currently perform this test, there is a high degree of expertise needed to interpret traces, and the test is lengthy as it lasts at least 6 hours (4 hours fasting and 2 hours post-prandial).

Capsule based technology, namely the wireless motility capsule (Smartpill) is similar to the wireless capsule endoscopy which looks at the small bowel mucosa, it is relatively non-invasive and doesn’t involve any radiation. It allows recording for up to 5 days, allowing the patient to go home and be in their own environment. The capsule itself currently measures temperature, pressure and pH. The pH data facilitates identification of entry into the large bowel due to a pH drop at the Caecum. There is a large data base with health controls which has been published giving very good reference values. The disadvantages of capsules are the cost and the chance of them failing or being retained. This wireless motility capsule is also not widely available in the UK.

Other Tests

The $^{13}$C octanoic acid breath test is used to diagnose gastric emptying. This is becoming more available on the NHS and is a simple non-invasive technique which gives similar results to scintigraphy without exposure to ionising radiation.

Hydrogen breath testing using lactulose is a simple, well tolerated and non-invasive technique which has been used to determine oro-caecal transit time. However, the test comes with major pitfalls such as the potential for substantial symptoms of bloating and distention. In addition lactulose can accelerate small bowel transit due to its natural osmotic activity. Dr Farmer agrees with the recent North American consensus that this method should not be used to investigate oro-caecal transit time.

Finally MRI-based testing assessed using small bowel MRI around regions of interest was discussed which allows you to obtain a parametric map of the deformation which then represents peristalsis, you can derive a number of useful parameters from this including luminal diameter and contraction ratio. Dr Farmer thinks this is where the field is going and moving in the future,
PPI therapy. Intractable nausea is also noted in a high proportion of SIBO positive patients.

The only direct means of diagnosing SIBO is by small bowel aspiration. This is unpleasant, complex and samples are generally taken from the duodenum only. BT is acknowledged to have relatively poor sensitivity and specificity for detecting SIBO and at present the consistency of the performance of the technique is poor. Accordingly the North American Consensus Group has recently published recommendations for standardising performance of BT*. In response AGIP is preparing initial recommendations for best practice in BT for the UK, which we hope will form the basis of a further consultation process with AGIP members and the broader GI community.

Anthony advocated for methane sampling, indicating that approximately 18% of patients for SIBO assessment are methane rather than hydrogen generators, rising to approximately 30% in patients with constipation dominant IBS.

He proposed an area of possible divergence with the American Consensus Statement breath hydrogen concentration thresholds for identification of SIBO. The American Consensus proposed a threshold of >20ppm breath hydrogen within 90 minutes post-ingestion of the substrate for identification of SIBO. His argument was that the time delay of 90 minutes would result in high false positive rates in patients with a short orocecal transit time due to normal large intestinal fermentation being inappropriately assigned to SIBO. Simultaneously those patients with SIBO generating lower hydrogen breath levels would be classified as normal with the relatively high hydrogen breath level threshold of 20ppm proposed by the American Consensus Group, leading to a high false negative rate. He therefore proposed an alternative threshold for identification of SIBO of a rise in hydrogen breath concentration of ≥10ppm within 60 minutes following ingestion of the substrate.

* Am J Gastroenterol 2017; 112:775–784
The RCCP recently gained accreditation with PSA. The Professional Standards Authority for Health and Social Care is an independent statutory body, accountable to Parliament. As an “over-arching” body, PSA sets robust standards to ensure that all registers accredited by it comply with a broad framework of quality and assurance which offers to patients, users and the public a new layer of protection. The Department of Health has issued advice to all NHS employers that where possible all staff should be registered at the appropriate level with a PSA accredited register. The Health and Care Professions Council (HCPC) is also accredited by PSA.

Implications for AGIP.

One aspect of being registered with a PSA accredited register is that it is now incumbent upon all registrants to be covered by an Indemnity Assurance. This indemnity cover is usually provided to all staff employed in a permanent post for the NHS. Indemnity cover is also usually provided to staff employed in a permanent post in the Private Sector. However, there are some caveats that may affect our members.

- Members who have extended their scope of practice should make sure that this has been recognised and authorised by employer.
- Those engaged in domiciliary work need to be particularly careful to check as this may be excluded under standard terms of cover.
- Those working under an Honorary Contract should check that this includes indemnity.
- Those offering a service to private patients within the NHS should check that this service is covered by their employer.

Members engaged in private practice in a self-employed capacity must obtain indemnity cover and for their own and patient safety should ensure that it covers them for all aspects of their work.
RCCP Membership

Membership of RCCP is open to our members at Graduate, Standard or Equivalent entry level. Anyone who completed the BSc in Clinical Physiology, a recognised training pathway\(^3\) or who has no academic qualifications but has a portfolio of experience can apply for registration\(^4\). This registration may be of interest to those of our members not already registered and who are not planning to apply in the near future for registration to HCPC. It will provide compliance with the DH’s advice to NHS employers as outlined above.

RCCP are also exploring the formation of a register for those working as Health Care Assistants and we will keep our members up to date with any developments.

**Any AGIP member or colleague not registered with RCCP and who requires further information on the above issues may contact Kathy Noble on the e-mail below:**

katherine.noble@heartofengland.nhs.uk

1. A full list of Accredited Registers can be found at [https://www.professionalstandards.org.uk](https://www.professionalstandards.org.uk)

2. The one known indemnity insurance company used by some of our members is the Medical Defence Union.

3. The GI reps on the Council hope to have the new Accredited Specialist Scientific Practice (ASSP) training pathway on the RCCP approved list.

4. RCCP at [https://www.rccp.co.uk](https://www.rccp.co.uk)