Welcome:

Welcome to the December issue of NewWave. Season’s greetings and all the best for 2016!

Dr Jeff Wright:

Jeff has only recently stepped down as Chair of AGIP. We would all like to take this opportunity to say a huge thank you to Dr Jeff Wright for his commitment and contribution over the last five years in his role as Chair. Jeff’s hard work and commitment given to AGIP members and the support and friendship he has provided to the council over the years has been invaluable, his energy and devotion to the role will be a hard act to follow. All the best Jeff, you will be missed.

AGIP Council:

The AGIP council needs new members. Please, please consider joining. You can make a real difference and it would help you with your equivalence application to the AHCS (if that is something you are considering). We meet quarterly at the BSG office, 3 St Andrews Place, Regents Park, London, all related expenses are reimbursed. Nomination forms need to be sent to Dr Kevin Knowles (kevin.knowles@nuh.nhs.uk). Form can be found on the BSG website: http://www.bsg.org.uk/sections/agip-membership/index.html.

Improving Quality in Physiological Services - IQIPS:

AGIP endorses the recommendations of the government’s Chief Scientific Officer (detailed within this issue of NewWave) with the expectation that all GI Physiology units should commence accreditation with IQIPS within the next 2 years.

AGIP Bursary Scheme:

After the success of the AGIP bursary scheme which allowed 9 GI Physiologists / Clinical Scientists to attend this year’s DDF meeting in London, the committee are delighted to announce and extension of this scheme to sponsor bursaries for the BSG meeting to be held in Liverpool, June 2016. We are particularly keen to encourage people to submit abstracts of original research for the meeting and applicants who have submitted abstracts will be given preference in terms of a successful application. AGIP have a joint ‘free papers’ session with the Neurogastroenterology and Motility section and a strong showing from
AGIP members is to be encouraged.

The bursary scheme will be for £300 per applicant and include allocation of a session for successful applicant to review and be subsequently published in NewWave. Deadline for applications will be January 31st 2016. If you need help in writing an abstract a mentoring scheme is available to AGIP members. For more details of this and the bursary scheme in general please contact Dr Anthony Hobson (anthonyhobson@hotmail.com).

NATIONAL STANDARDS FOR INVASIVE PROCEDURES (NatSSIPS)

Reviewed by: Professor G Duthie, AGIP President & Patricia Vales, RCCP representative GI Physiology.


Although these new standards are aimed specifically to reduce incidents related to invasive surgical procedures there are “take home” messages for all Clinical Physiologists, but especially those working in Gastroenterology and Cardiology.

These new standards set out broad principles of safe practice and advise healthcare professionals on how they can implement best practice, such as through a series of standardised safety checks and education and training. The standards also support NHS providers to work with staff to develop and maintain their own, more detailed, local standards and encourage the sharing of best practice between organisations.

WHAT DOES THIS MEAN FOR ME?
The standards published provide a framework for local standards to be established. The recommendations which impinge on the work of Clinical Physiologists come under the following headings:

If you are the managerial or clinical leader of a service that performs invasive procedures, you should work with those Healthcare Professionals directly involved in the performance of invasive procedures to create Local Safety Standards for Invasive Procedures that are deliverable and practicable, and support safe patient care rather than distract people from it. You should ensure that time is available for team training in the delivery of safe care.

If you are a healthcare professional who is a member of an invasive procedure team (or carrying out an invasive procedure), you are the one who should feel a real sense of ownership of the local standards. You should contribute towards their creation, documentation, audit, review and development. You should participate fully in the safety checks and steps built into the standards. You are also the one who should speak up if they have any concerns at all about the care that the patient is getting. You are the one who makes safer patient care a reality.

WHAT ARE INVASIVE PROCEDURES?
The National Institute for Health and Care Excellence (NICE) defines an “interventional procedure” as a procedure used for diagnosis or for treatment that involves:
Making a cut or a hole to gain access to the inside of a patient's body – for example, when carrying out an operation or inserting a tube into a blood vessel
Gaining access to a body cavity (such as the digestive system, lungs, womb or bladder) without cutting into the body – for example, examining or carrying out treatment on the inside of the stomach using an instrument inserted via the mouth
Invasive cardiological procedures such as cardiac catheterisation, angioplasty and stent insertion
Endoscopic procedures such as gastroscopy and colonoscopy
Interventional radiological procedures.

WHAT IS THE PROCEDURE TEAM?
All those involved in the performance of the procedures, including doctors, nurses, midwives, operating department practitioners (ODPs), healthcare assistants (HCAs), technicians, scientists (clinical physiologists) and any others directly involved in the performance of the procedure.

WHO IS AN OPERATOR?
Includes the surgeon, endoscopist, cardiologist, obstetrician, midwife, radiologist or other healthcare professional or practitioner performing the invasive procedure.

COMMENT/ TAKE HOME MESSAGE
Most established Clinical Physiology units offering diagnostic and therapeutic services will have established these standards and, through RCCP and the Professional Bodies, will be ensuring the highest standard of training of physiologists delivering these invasive procedures.

However this publication not only reinforces our individual responsibilities but also provides us with a tool to counteract the growing number of employers who set up these services without reference to established practice. Healthcare Professionals in such services often approach established services for advice and can now be referred to these standards. NICE intends to publish Guidance and Guidelines for Diagnostic Services by 2017 and is currently asking for stakeholders to register and comment on draft proposals: [https://www.nice.org.uk/guidance/indevelopment/gid-cgwave0773/consultation/diagnostic-services-consultation-on-the-draft-scope](https://www.nice.org.uk/guidance/indevelopment/gid-cgwave0773/consultation/diagnostic-services-consultation-on-the-draft-scope)

RCCP Update December 2015
RCCP continues to attract registrants in Clinical Physiology (approximately 6000 registrants) and continues to campaign across all of the four countries for Statutory Regulation. It does this by responding on our behalf to any current affair which impinges on our profession and engages through lobbying with the Department of Health, both Houses of Parliament at Westminster and all of the Devolved Parliaments. As an example of the work that is being done RCCP met with members of the Health Select Committee 21st Oct (Dr Sarah Wollaston MP (Chair of Health Committee), Dr James Davies MP, Maggie Throup MP, Rachel Maskell MP, Dr Philippa Whitford MP and Paula Sheriff MP (members of the Health Committee)) who have asked to set up a date to present to the full Committee as they support our position on statutory regulation and this will help them raise the issue to government.

The Register is open for applications from students to fully qualified Clinical Physiologists and will continue to be open for applicants from GI physiologists through either the BSc Clinical Physiology route or through the 6 year Equivalence route. There is also an M-level register for experienced Clinical Physiologists; the latter leading to application to the Chartered Scientist register. The M-level register is open to anyone working at the appropriate level and does not require prior registration with RCCP nor is there a minimum time in service requirement. A mentor is allocated to anyone interested in this level of membership to advise and guide through the application process. RCCP will also pay the Professional Body registration fee to the CSci register should there be enough of our members interested in becoming a Chartered Scientists.

The Council maintains close contact with The Academy of Healthcare Science and continues to work with The
National School of Healthcare Science to ensure Education and Training standards for Clinical Physiologists are maintained.

Most importantly very close contact is maintained with the Professional Standards Authority (PSA) and RCCP has ensured that where necessary changes to the membership of the Council and criteria for registration have been made to ensure that the RCCP register is in a position to apply for Accredited Voluntary Registration status and is also in contact with other voluntary registration bodies such as IPEM that are also considering this route.

RCCP has also introduced a Whistleblowing Insurance which provides legal expenses insurance, guidance prior to blowing the whistle and counselling service afterwards. This service is available through whistle blowing insurance helplines at RCCP. As healthcare professionals we have a Duty of Candour to the patients in our care and this insurance will provide us with support should we need to speak out against practices detrimental to safe patient care. https://www.rccp.co.uk/articles/154/Whistleblowing

RCCP continues to be relevant to GI Physiologists and offers a registration pathway for the majority of our membership.

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**Functional Gut Clinic @ Peterborough City Hospital is first NHS centre to gain IQIPS accreditation.**

Our innovative Functional Gut Clinic service in conjunction with Peterborough City Hospital has been extended for three years and become the first NHS centre in the UK to gain IQIPS accreditation.

Michelle Gavin, Endoscopy Specialist Nurse, said: “We recognised we had large numbers of patients who needed specialist GI Physiology Services but we were unable to provide this locally with patients having to go on a waiting list for this service at Addenbrooke’s Hospital.

“The supply of such services are sparse and specialised, and we didn’t have the specialist equipment or staff, but endoscopy colleagues were aware of Dr Hobson’s Functional Gut Clinic in London and his services at other NHS centres, so we established a pilot clinic to provide services locally.

“We’ve been able to provide GI Physiology two days a month in our endoscopy clinic, provided by Dr Anthony Hobson, who is a Consultant Clinical Scientist and provides all of the equipment and specialist skills.

“The service provides a wide range of tests including High-Resolution Oesophageal Manometry and Impedance (HRiM), an advanced swallowing assessment, which measures muscle function and swallow clearance in the oesophagus, as well as sphincter function for patients with acid reflux or dysphagia (swallowing problems); 24 hour pH / Impedance studies which monitors acid and non-acid reflux over a 24-hour period; and expanding hydrogen / Methane breath testing to look for small intestinal bacterial overgrowth (SIBO) and intolerances to sugars such as lactose and fructose which can cause severe bloating.

“The service means around 20-30 patients a month can be seen locally, without having any delays, as the number of clinics is increased around demand, meaning we don’t have a waiting list of patients.

“It’s excellent news for patients and the team that we are providing this service for another three years. With the extension we thought it was important to extend the scope of our IQIPS accreditation to cover Peterborough as a badge of quality and excellence to reassure local patients and commissioners that they are...
“There has been a leap in technology which is not widely available in most NHS centres and a lack of qualified staff, which can cause these services to be limited,” said Dr Hobson. “I trained in the NHS in Manchester and my practice at The Functional Gut Clinic provides clinics in London, Kent, Coventry, Nottingham with other new services coming online in the next few months. Whilst our London Clinic is predominantly for private patients we are excited to be able to offer the same level of service on a broader level to NHS patients working within tariff and in collaboration with local hospitals. It helps to put GI Physiology at the centre of GI services and we have been able to help endoscopy staff understand what the new advances in GI Physiology technology can bring to the diagnostic process.

“We are able to provide these ‘mobile’ clinics which means the Trust doesn’t have to invest in the expensive equipment or the use inadequately trained staff to perform procedures. I enjoy working with the endoscopy team, and the nurses are able to observe and be trained in the new procedures. I very much look forward to continuing to provide the services in Peterborough.”

www.thefunctionalgutclinic.com

A simple test for Lactose Intolerance – H₂ Check

The H₂ Check is an easy to use hand held device for the simple detection of Hydrogen on the breath. A single breath test will display H₂ results in PPM, and can be used on all age groups and types of patients. Features include single switch operation, fast results in PPM, rapid response time and a unique re-breathing system.

Other applications include; Lactose mal-absorption, carbohydrate mal-absorption, bacterial overgrowth, intestinal transit time, sucrose and fructose mal-absorption and lactulose bacterial overgrowth.

For more information and a demonstration please contact;
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Ardmore Healthcare
A Reflux Conundrum for Physiologists:

1Oesophageal Laboratory, Guy’s & St Thomas’ NHS Foundation Trust
2Gastroenterology, East Kent Hospitals University NHS Foundation Trust

Introduction: Oesophageal hypersensitivity (OH) has been observed in oesophageal pH monitoring as normal degree of gastro-oesophageal reflux (GOR) exposure and positive symptom-reflux association (SI+ and/or SAP +). The diagnosis of OH tends to divert the clinical management from anti-reflux surgery to pain modulation therapy. The purpose of this study is to investigate any changes in the diagnosis of OH when prolonged reflux monitoring is applied.

Method: All patients with heartburn and/or chest pain referred for prolonged wireless reflux monitoring in the period of Jan 2010 - Feb 2015 were selected for this retrospective study. Those with a positive reflux-symptom association for the above symptoms during the first 48hrs of recording were included. The cut off for positive symptom association probability (SAP) was ≥ 95% and a positive symptom index (SI) was ≥50%. The total duration of reflux monitoring was 96hrs. Presence of pathological GOR on the 3rd and/or 4th 24hrs of recording was considered as positive GORD. Change of diagnosis from oesophageal hypersensitivity to true reflux was identified.

Result: 183 patients with normal wireless pH monitoring at 48hrs completed a full 4 days study. During the 1st 48hrs, 40 patients had positive SAP and/or SI for heartburn (13M, 27F). Of these, 12 (30%) showed pathological GOR on extended monitoring (3M, F9). The prevalence of pathological GOR on extended monitoring was: 11/38 (28.9%) patients with SAP+ (regardless of SI), 4/13 (30.7%) with SI + (regardless of SAP), 8/27 (29.6%) with SAP+ and SI –, 3/11 (27.3%) of those with both SAP and SI +. Only 2 patients were SAP –, SI + and only one had reflux.

During the first 48hrs, a total of 27 patients (8M, 19F) with chest pain, had positive SAP and/or SI. Of these, 5 (18.5%) showed pathological reflux (M: F 1:4) during extended reflux monitoring. The prevalence of pathological GOR on extended monitoring was: 5/24 (20.8%) SAP + patients (regardless of SI), 4/10 (40%) with SI+ (regardless of SAP), 1/17 (5.9%) with SAP + and SI –, 4/7 (57.1%) with both SAP and SI +.

Discussion: This study suggests 20-30% patients with OH, who complain of heartburn or chest pain, do have true pathological GOR as demonstrated by the extended reflux monitoring. This study also suggests 24-hr pH monitoring may not be sufficient recording time to investigate for pathological GOR in some patients with OH which may be apparent at first glance. It is possible that patient may not have their usual day or typical symptoms during the reflux monitoring. We recommend considering quantifying the patients usual day in terms of activity and also the severity of reflux compared to other days using analogue scales. Depending on the answers patients may require repeat testing or have prolonged pH monitoring. This will also apply to patients who have phases of symptom and symptom-free. Repeat studies or prolonged monitoring should also be considered in OH patients who show >1cm hiatus hernia on HRM and/or have oesophagitis (higher than grade 1) as these factors are associated with pathological GOR. These modifications to the currently existing study tools used in clinical practice may aid the elimination of misdiagnosed OH.

Conclusion: This study brings awareness that up to 30% of OH patients may in fact have pathological GOR which can go undetected for two consecutive days of pH monitoring. This may be owing to day-to-variability in reflux and may require repeating pH monitoring that should ideally not be done on the following day when OH criteria has been met. Analogue scales to gauge patients’ usual day and symptom severity are advised. If the method of reflux monitoring using catheterisation is severely restricting patients having a usual day, then they should be referred for wireless pH monitoring.
AGIP endorses the recommendations of the government’s Chief Scientific Officer (detailed below) with the expectation that all GI Physiology units should commence accreditation with IQIPS within the next 2 years.

Chief Scientific Officer bulletin: June 2015

Voicepiece

It should almost go without saying, but quality has to be central to all that we do. Quality is the key factor in delivering improved outcomes for patients. Recognising, driving and delivering quality in what we do is a key determinant of us being able to call ourselves professionals.

However, it isn’t enough to believe that you’re delivering a quality service – anyone can claim to be great. Real quality doesn’t happen by chance but – just like scientific development – it occurs through a continual process of analysis, challenge, assessment and action that acts as a driver for continual improvement.

This is why accreditation schemes are so important. Independent assessment provides an objective view of what is being delivered and the standards, approach and protocols of the accreditation process itself do an enormous amount to embed a quality culture within each individual service.

We have seen substantial progress over the past few years in developing and embedding accreditation across healthcare science. We’ve built on the long experience of pathology colleagues from CPA to ISO15189 bringing in IQIPS for physiological sciences.

NHS England has identified the accreditation of scientific and diagnostic services as a business plan priority and the extended quality role has been recognised by the Care Quality Commission as a cornerstone of its inspection regime.

The response from scientific teams is also impressive. We’re seeing more and more services signing up to healthcare science accreditation schemes, demonstrating their commitment to quality, recognising the value as an improvement tool and showcasing the quality of their science and scientists.

Nothing becomes us more as scientists, and as healthcare professionals, than confirming our commitment to quality. And there is no substitute to demonstrating this objectively and transparently through service accreditation.

For more information regarding accreditation please visit the IQIPS website https://www.iqips.org.uk/ or contact Warren Jackson (AGIP Chair and IQIPS assessor).

Forthcoming Events 2016:

We hope to publicise forthcoming meetings and educational events. We would like to invite interested parties to contact the NewWave editor (warren.jackson@hey.nhs.uk) to have the details included in future NewWave publications.

21st - 24th May 2016 Digestive Disease Week (DDW)
San Diego Convention Centre, San Diego, California

For further details go to: http://www.ddw.org/

Liverpool ACC, Liverpool

Further information will be made available soon: http://www.bsg.org.uk/events/bsg-annual-meeting-2016.html

15th - 19th Oct 2016 United European Gastroenterology (UEG) Week
ACV, Vienna, Austria

Further information will be made available soon: https://www.ueg.eu/week/past-future/ueg-week-2016/
Background to the Biofeedback development

The mcompass System, with the Biofeedback therapy software, was recently selected by the National Institute of Child Health and Human Development (NICHD) Pelvic Floor Disorders Network to be used in the CAPABLE study (Controlling Anal incontinence by Performing Anal exercises with Biofeedback or Loperamide). The goal of this randomised placebo-controlled trial, involving seven research institutions, is to learn more about medication and pelvic muscle training treatments for faecal incontinence (accidental bowel leakage). Specifically, this study will compare Pelvic muscle training with drug treatments for faecal incontinence to see if one treatment or both together are better than usual care at improving this condition. The team at Medspira learned a lot about what is necessary for both the clinicians and patients relating to anorectal manometry and biofeedback using manometry.

For further information and evaluation contact:
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