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BRITISH SOCIETY OF GASTROENTEROLOGY

New Wave

The Official e-Newsletter of the Association of GI Physiologists

AGIP Council 2025

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October 2025

Welcome

Welcome to the **October 2025** edition of NewWave!
If you have any relevant articles or papers that you would like to be included in future editions, please email Gemma Willis

CONTENTS

From the Editor

Hello, and welcome to the autumn issue of NewWave!

As we move into the final part of 2025, this edition brings together a brilliant mix of updates from across the GI Physiology community.

To begin with, I'd like to take a moment to say a huge congratulations to Samantha Scott on the safe arrival of baby Henry! We're all so thrilled for her and her family. While Samantha takes a well-earned break for maternity leave, we're delighted to welcome Warren Jackson, who has kindly stepped in as Acting Chair during her time away. Warren is no stranger to the AGIP Committee and so we are definitely in safe hands in Sam's absence.

This issue kicks off with a look ahead at upcoming courses and conferences on Page 3. This is a perfect way to plan your CPD for the months ahead. The AGIP Masterclass is due to take place on 21st November and there are still a few places left. Be quick if you don't want to miss out, it's going to be a really informative and enjoyable event! If you are hosting any training and would like to advertise this in NewWave, please don't hesitate to get in touch! On Page 4, we've included details of an upcoming vacancy job opportunity and details of how to apply.

On Page 5, you'll find a summary of the discussions from the AGIP Council meeting held in September 2025, highlighting some exciting developments and continued projects. It's important to see the progress happening behind the scenes to support the national growth of GI Physiology and I hope you enjoy reading about the ongoing work.

This issue also shines a spotlight on two new faces within the AGIP committee. On Page 6, Samantha Morris introduces herself as the new National Standards Officer, sharing her plans for promoting consistency and quality across clinical reporting and guidance. Then, on Page 7, we meet Sam Ndaa, the new Trainee Representative, who gives us an insight into his journey so far and his goals for supporting current and future trainees. This is the first time a trainee position has been available in the AGIP Committee and we are looking forward to the unique perspectives that Sam will bring to this role.

Moving onto our feature articles, on Page 8 and Page 11, we travel to Berlin for United European Gastroenterology (UEG) Week 2025, where both Catherine Sykes and Grace Fairlamb share their experiences of attending the conference to present their research. Catherine and Grace were awarded the AGIP European Bursary to assist with their travel expenses, and it sounds like it was an incredibly rewarding experience. Well done, girls!

Finally, on Page 14, I've contributed a piece reflecting on life as a fourth-year HSST student, the ups, downs, and ultimately why I think it's still worth it. Hopefully, this will resonate with anyone currently considering the HSST pathway!

As always, I'd like to say a huge thank you to everyone who has taken the time to contribute to this issue. If you'd like to get involved, share your department's work, or write about an event you've attended, please don't hesitate to get in touch — I'd love to hear from you.

Happy reading!

Gemma Willis

Upcoming Events 2025

November 2025	**High Resolution Pharyngeal Manometry: Interpretation and Approach** 7th November 2025 at 12pm-1.30pm Webinar **AGIP Masterclass** 21st November 2025 at 8.30—5pm **Manchester** The British Society Of Gastroenterology Conferences & Events **Impedance-pH Studies: Interpretation in Detail** 26th November 2025 at 10-11am Webinar
December 2025	**Chronic Constipation: Pathophysiology, Investigation and Management** 9th December 2025 at 1.30-3pm Webinar
January 2026	**UHNM Pelvic Floor Imaging Workshop** 15th—16th January 2026 Stafford UHNM Pelvic Floor Imaging Workshop | The Pelvic Floor Society **26th International Conference on Gastroenterology and Hepatology** 19th—20th January 2026 Vienna Gastroenterology 2026 | January 19-20, 2026 | Vienna, Austria
March 2026	**Pelvic Floor and Proctology Course 2026** 2nd—3rd March 2026 London Pelvic Floor and Proctology Course 2026 - St Marks Academic Institute
April 2026	**UKCS 2026 Annual Scientific Meeting** 22nd—24th April 2026 Bradford The United Kingdom Continence Society
May 2026	**Digestive Diseases Week** 2nd—5th May 2026 Chicago, Illinois Home Page - DDW **31st UKCS Annual Scientific Meeting** 8th—9th May 2026 London United Kingdom Continence Society - UKCS 2025
June 2026	**BSG Live'26** 22nd—25th June 2026 **Liverpool** BSG Live'26

Job Vacancy: Clinical Scientist Southampton General Hospital

An exciting Band 7 Clinical Scientist opportunity is available at Southampton General Hospital to join the GI Physiology team on a 6-month fixed-term contract (full-time, part-time, or flexible working considered).

The post involves performing a wide range of specialist GI investigations — including oesophageal manometry, pH impedance, hydrogen and methane breath testing, anorectal physiology, and wireless pH monitoring — alongside producing advanced diagnostic reports, contributing to multidisciplinary care, and maintaining high standards of quality and safety.

Employer: NHS Professionals
Location: Southampton General Hospital, Tremona Road, SO16 6YD
Closing date: 14 November 2025
Pay: Band 7 — £27.98 per hour

For further details or to apply, click here or contact Vanessa Chung for more information.

AGIP Council Meeting 9th June 2025

The AGIP committee met on 8th September 2025 at BSG HQ in London to review ongoing projects and plan the months ahead.

The committee welcomed to their roles Samantha Morris, who has officially started in her role as National Standards Officer, and Sam Ndaa, who joins as Trainee Representative.

A key area of discussion centred on AGIP's identity and structure. It was agreed that the organisation will now formally be referred to as the Association of GI Physiology, simplifying the title while keeping the well-recognised acronym AGIP. The committee also reviewed the Terms of Reference, confirming updates around membership terms and chair tenure to strengthen governance and consistency.

With Samantha Scott now on maternity leave, Warren Jackson will act as Interim Chair, supported by John Hayman and John Gallagher to ensure business continuity. The role of Minute Secretary is currently vacant following Deepa Solanki's departure; Gianni Raise will provide interim support until the post is advertised in the March 2026 elections.

Discussions then turned to the AGIP Masterclass, which is fast approaching and will take place in Manchester this November. The agenda is now live on the BSG website, and sponsorship has been confirmed from Laborie and Geomed, helping to secure another excellent educational event for members.

The committee revisited workstreams from earlier meetings, including the development of national reporting standards for GI physiology tests. This project, continues to progress well, with draft templates soon to be circulated for feedback.

Further updates included plans for a new equivalence route to accreditation, allowing experienced practitioners who have not completed traditional STP or ASP pathways to gain AGIP recognition through portfolio and EPA assessment. This will run alongside existing ASP and STP routes, ensuring inclusivity while maintaining high professional standards.

Other agenda highlights included the introduction of social media initiatives to enhance member engagement, and the continued redevelopment of the AGIP website and handbook, ensuring all guidance and training materials remain current.

Finally, the new AGIP logo options were presented for the first phase of discussion and feedback. The final design is expected to be unveiled at the December 2025 meeting.

The next AGIP Committee meeting will take place on Monday 8th December 2025.

Introducing AGIP's Latest Committee Members: Samantha Morris, National Standards Officer

Hello. My name is Sam, and I have recently joined the AGIP Council. I have been working within GI Physiology for 13 years now, qualifying from the STP as a GI Clinical Scientist back in 2015. I really enjoy my job, and I am so glad to have found a career that is so interesting, whilst also worthwhile and beneficial for our patients, many of whom have really debilitating conditions.

I began my career at Sheffield Teaching Hospitals, where I trained and qualified through the STP. I then moved down to London and specialised in Lower GI Physiology - first working in the Pelvic Floor Unit at Guys and St Thomas', then I moved to become the unit manager for the Lower GI Physiology Unit at the Royal London Hospital, Barts Health. Throughout these roles I worked with 3 wonderful teams, who I am so grateful for and who taught me a lot along the way. During my 8 years working in Lower GI Physiology in London, I honed my expertise in a variety of investigations (including anorectal manometry, endoanal ultrasound, total pelvic floor ultrasound, barostat, transit studies and fluoroscopic proctography) and therapeutic treatments (including conservative management, visual biofeedback and sacral neuromodulation).

During this time, I developed a keen interest in research, becoming involved in several clinical studies, and contributing to a range of publications. I have been fortunate to attend many conferences - one highlight is the International Continence Society meeting in Tokyo. It was my first international conference and such a wonderful city to explore! I won an Early Careers Award to fund that trip, which I was very surprised to get. If you are wondering about whether to apply for a conference award which could take you somewhere exciting, do give it a try you never know!

A few years ago, now, I then relocated with my family back home to the Midlands. I now work within the GI Physiology team in a Clinical Measurement Department at the Royal Derby Hospital. I have continued my Lower GI Physiology work, whilst also rejoining the world of Upper GI Physiology. It was fascinating to discover all the changes and developments that have happened to these upper GI investigations in such a short time.

Outside of work I live with my husband and our almost 4-year-old little girl. We love to spend time outside, perhaps on a nice walk or trying out a new playground. Recent highlights include an autumn forest holiday at Center Parcs, and an afternoon spent pumpkin picking at one of our local farms.

Having now worked in 4 different GI Physiology Units in different NHS Trusts, I have developed a passion for co-ordinated work between centres. Working together to build on all our amazing work and achievements, rather than working as competing teams. Since moving to Derby, I have joined the regional network groups. Initially attending the Northern meetings, then more recently the newer Midland Network meeting. It has been wonderful to meet colleagues at other local centres and build a collaborative working relationship with them.

I was very pleased to then have the opportunity to join the AGIP Council and join the lovely team of people who have already been working to lead our profession at a national level. I have been given the role of National Standards Officer. As the name suggests, this involves standardising processes across the profession. I will be leading the development and co-ordination of national standardised documents, such as Standard Operating Procedures, clinical guidelines, and best practice pathways, for use by AGIP members and, where appropriate, the wider healthcare science and clinical community. For example, guidance on the essential elements to be included in a particular report. In the near future, we will be publishing lots of documents and resources to help us all in our clinical practice. Hopefully, this will be useful to everyone and will help to ensure best practice.

Introducing AGIP's Latest Committee Members: Samuel Ndaa, Trainee Representative

Hello everyone,

I'm excited to introduce myself as the new trainee representative for AGIP! I'm currently in my third year of the Scientist Training Programme, working within the GI Physiology department at Hull University Teaching Hospitals. My journey into GI physiology started during my Physiological Sciences degree at the University of Sunderland, where I developed a strong interest in gastrointestinal, respiratory, and urodynamic sciences. I went on to work in respiratory physiology at Newcastle Hospitals before moving to Oxford as an Assistant Practitioner in GI Physiology — an invaluable experience that gave me real insight into how a busy GI department operates and prepared me well for the STP.

I'm passionate about being a voice for trainees because I know how important it is to feel supported and connected, especially when starting out. My aim is to create opportunities for collaboration, share advice and helpful knowledge, and keep trainees informed about developments they might not otherwise hear about. Most importantly, I want trainees to know they're not alone — we're in this together, and our voices matter.
Alongside this, I'll also be helping to support AGIP's social media presence. This is something I'm especially excited about, as I believe it's a fantastic way to raise awareness of our profession — both among aspiring healthcare scientists considering their career paths and the wider public, who often don't know the important work we do.
Outside of work, I'm part of a gospel choir in Newcastle, performing at events and gigs throughout the year, and I love spending time with friends and family whenever I get the chance.

I'm really looking forward to connecting with as many trainees as possible, so please feel free to reach out if you'd like to chat, share ideas, or get involved.

United Gastroenterology Week 2025: Berlin

by Catherine Sykes, Clinical Scientist
The Newcastle Upon Tyne Hospitals NHS Foundation Trust

As a newbie to both Berlin and UEGW I was struck by the scale and diversity of both. Berlin, with its rich and profound history, sits against a vibrant backdrop: an eclectic hot pot of culture, where it seems that (just about) anything goes! UEGW was daunting on arrival, but the conference venue quickly became familiar and it was exciting to be mixing with people whose work you read about, but whom you don't expect to be sitting next to!

The moderated poster sessions provided an opportunity to present to an international audience from mini stages in the main conference room, where people gathered to listen to other peoples' work. Despite being nerve wracking, our team delivered clear and interesting presentations that were well-received and stimulated interesting Q&As. My poster was titled: 'Impedance as a Marker of Mucosal Integrity in Eosinophilic Oesophagitis: Mean Nocturnal Baseline Impedance and High-Resolution Impedance Manometry'. I gave a brief overview of the SWALLeOeW study, which is an ongoing, prospective study into the use and acceptability of oesophageal physiology testing in Eosinophilic Oesophagitis (EoE) (ISRCTN17786884). I explained that as part of this, we collect data on mucosal impedance both during 24-hour pH/impedance monitoring but also during high resolution impedance manometry (HRIM). After discussing that low mucosal impedance has been associated with reduced mucosal integrity and is most usually defined using the parameter mean nocturnal baseline impedance (MNBI)[1], I explained that we wished to see whether we could collect comparable data on baseline impedance during HRIM.

I described how the data was collected, with MNBI measured using established methodology from Professor Sifrim's group[1]. Impedance during HRIM was calculated during the supine resting pressure and manually exported from the software (Medtronic). The two distal impedance channels just proximal to thelower oesophageal sphincter (LOS) were used, in order to map to those channels used in the MNBI measurement (Figure 1).

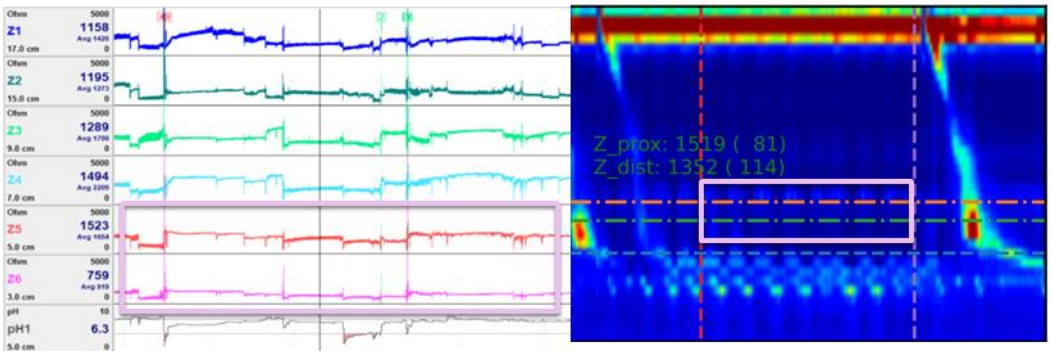


***Figure 1**: Left, MNBI measurement (Laborie, Ohmega). Average impedance from distal channels 3 & 5 cm above the LOS used. Right, impedance measured in resting measurement during HRIM (Medtronic). Sensors 2.5 & 4.5 or 3.5 & 5.5 cm above LOS used. Pink box indicates example measurement frame.*

The results relating both to the practicability of obtaining the data, and the comparability of the measurements obtained were discussed. From 42 possible participant visits, 22 paired HRIM and MNBI measurements have been obtained to date. Reasons for unsuccessful measurements are shown in Table 1 and were comparable across the two technologies.

Table 1	MNBI	HRIM
Not attempted	2	2
Not tolerated	10	8
Nickel allergy	1	NA
Drop out	2	2
Unable to intubate	1	0
Reflux during resting measurement	NA	1
Catheter failure	0	1

I explained that the mean impedance values as measured by the two methods were not significantly different: mean MNBI (95% CI): 1570 (1210- 1930) ohms, HRIM (95% CI) = 1330 (920-1740) ohms, p = 0.18. I then discussed the Bland-Altman plot (Figure 2), explaining that whilst the green line suggests good agreement between the two methods, MNBI does appear to read slightly higher, with a mean difference of 245 ohms (1380-1870) (5-95th percentiles). The data had then been categorised as normal or abnormal values for each technology, using established normative thresholds of >1500 ohms[2]. This demonstrated agreement between the two methods in 19/22 measurements. The three data points (circled yellow, Figure 2) were compared to absolute eosinophil count from oesophageal biopsies, with 2/3 appearing to agree better with MNBI and 1/3 appearing to agree better with HRIM.

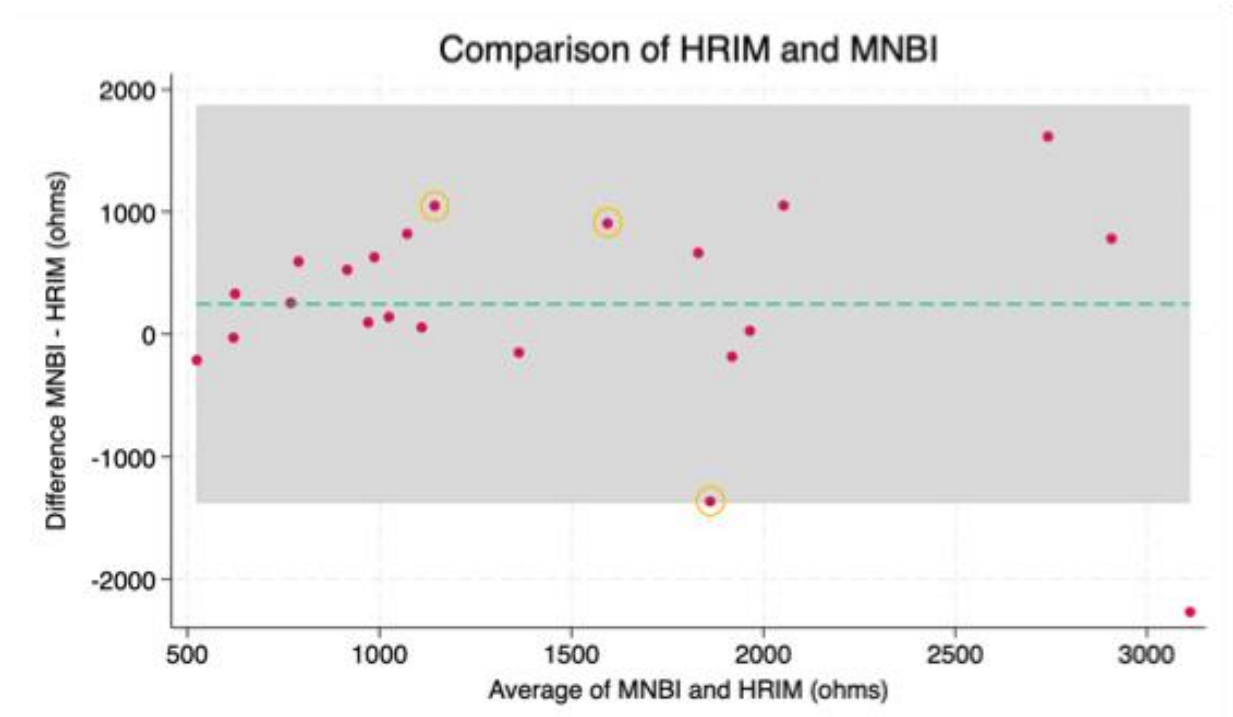


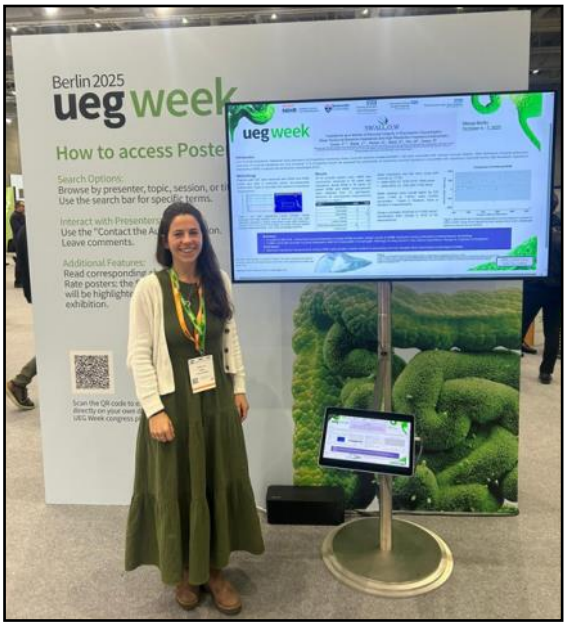
***Figure 2**: Bland Altman plot comparing oesophageal mucosal impedance measured by HRIM or MNBI. Orange circles highlight the three readings which result in classification differences between the two methods.*

Finally, I summarised by saying that measurement of impedance during HRIM appears to be comparably practicable to MNBI measurement in patients with EoE, with the same numbers of successful measurements achieved by the two methods. This preliminary data also indicates that there may be good agreement between methods. Further work in the SWALLeOeW study will correlate mucosal impedance findings with the Eosinophilic Oesophagitis Histology Scoring System[3]. I concluded by saying that impedance measurement during HRIM could provide a faster method of assessing mucosal integrity in EoE, whilst simultaneously assessing oesophageal motility.

Following the presentation, I was asked a number of questions from the audience about the use of mucosal impedance as a marker of mucosal integrity and whether we used this clinically. I was also asked about the clinical application of the work. I expanded on the idea that if it transpires that assessment of oesophageal motility during eating is valuable in EoE (wider aims of the SWALLeOeW study), then assessing mucosal impedance during HRIM could also provide a fast method of assessing the mucosa, which could allude to mucosal health and even response to therapy, if patient is already undergoing active EoE management.

That evening I attended the EUREOS EoE symposium, where the topic of immunology and the molecular basis of EoE were discussed in an in-depth, yet accessible manner by Professor Oscar Palomares from Spain. The highlights for the rest of the conference included hearing Amanda Cordell speak on behalf of the EOS network in the 'Meet the patient organisations' session. Here she explained the difficult journeys of patients with eosinophilic disease and the work of EOS network in advocating for patients. I was also interested to learn that patient organisations also go through accreditation standards, with one organisation describing how they had been through ISO 9001. A particularly enjoyable talk was given by Marc Benninga from the Netherlands on 'Motility mayhem: the paediatric battle with gut disorders' where he compared the efficacy of peppermint oil, placebo or peppermint sweets in children with functional abdominal pain, finding that adequate symptom relief was achieved in ~50% across all groups, with no difference between groups. He highlighted the power of the placebo, which, in this context, is even higher in paediatrics than in adult populations and advocated the use of peppermint sweets which are cheap, harmless and effective in about half of patients. I was also pleased to see that UEG are putting together guidelines on PPI use, which will be out next year. In a time where patients are questioning these medications and their side effects more than ever, this will hopefully be a helpful summary of the current evidence base.

In a time where financial constraints dominate the NHS and public sector, I am aware how fortunate we were to go to this conference. It was a great introduction to an international event and amazing to see the collaborative work that UEG does, in action!



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1. Hoshikawa, Y. *et al.* Measurement of Esophageal Nocturnal Baseline Impedance: A Simplified Method. *J Neurogastroenterol Motil* **26**, 241–247 (2020).
2. Sifrim, D. *et al.* Normal values and regional differences in oesophageal impedance-pH metrics: a consensus analysis of impedance-pH studies from around the world. *Gut* gutjnl-2020-322627 (2020) doi:10.1136/gutjnl-2020-322627.
3. Collins, M. H. *et al.* Newly developed and validated eosinophilic esophagitis histology scoring system and evidence that it outperforms peak eosinophil count for disease diagnosis and monitoring. *Diseases of the Esophagus* **30**, n/a-n/a (2016).

United Gastroenterology Week 2025: Berlin

by Grace Fairlamb, Clinical Scientist
The Newcastle Upon Tyne Hospitals NHS Foundation Trust

I was lucky enough to attend UEGW 2025 in Berlin and present my work as part of a moderated poster session. I presented my poster on a prospective service evaluation to assess the impact of obstetric anal sphincter injuries (OASI) on anal sphincter anatomy and function using anorectal physiology. We also looked at the impact this had on mode of delivery decision making. The service evaluation focused on results from pregnant patients with a history of 3rd or 4th degree tear who were referred for anorectal physiology to inform their mode of delivery.

Patients with an abnormal squeeze and patients with external anal sphincter scarring of >30° on ultrasound were considered to have significant abnormalities and were counselled for c-section. We obtained results for 24 patients which are outlined in the figure below.

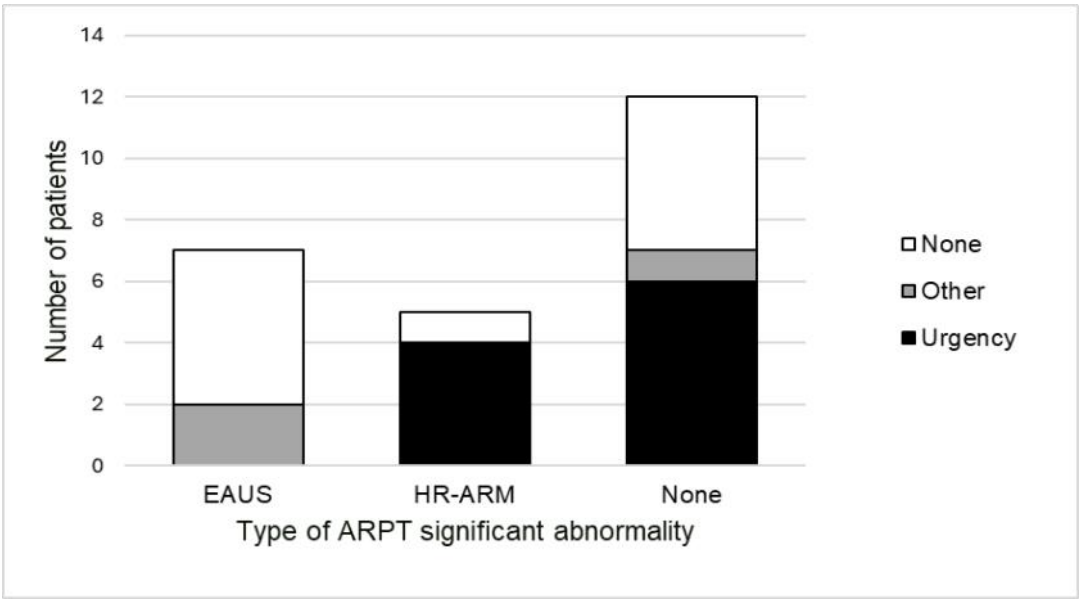


Figure 1: Graph depicting the type of significant abnormality during anorectal physiology and the symptoms this cohort presents with. ARPT: Anorectal physiology testing, HR-ARM: high-resolution anorectal manometry, EAUS: endoanal ultrasound.

The results showed poor agreement between endoanal ultrasound defects and impaired squeeze function (0% overlap) which highlights the need for both manometry and ultrasound in mode of delivery decision making. Majority of patients with an abnormal squeeze had urgency. Only 2 with defects on ultrasound had bowel symptoms, one was of passive incontinence, and one was difficulty emptying their bowels. The results also showed bowel symptoms were common in patients with no significant abnormality on testing.

In addition to this, patients also filled out questionnaires after childbirth to capture the impact of the results on their delivery. The response rate was poor (33%), but all patients reported anorectal physiology influenced their mode of delivery and all patients were happy with their delivery. However, only 1 patient changed their intended delivery following their anorectal physiology results.

I concluded that overall, this highlights the need for physiology in these patients as historically they all would have been advised to have a c-section; however, a significant defect was only

observed in half of the patients. Furthermore, the feedback from patients was positive, highlighting the impact of the results on their care.
I was asked questions on why I thought the findings did not match up, particularly those of perceived urgency and lack of abnormalities on physiology testing. I explained that the pathophysiology of urgency is complex and can be due to factors other than patient physiology, such as stool consistency.

I was also asked what I thought about the fact that only one patient had changed their mode of delivery following their anorectal physiology tests. The data on the poster hadn't quite captured that some patients already intended to have a vaginal birth and having normal test results just improved their confidence in their decision.
Presenting my poster at UEGW initially sounded very daunting but it was a relaxed and enjoyable experience, and it was a great opportunity to interact with experts in the audience.

The rest of the conference was full of a wide range of inspiring talks on different areas of the GI tract. One session I found very interesting was on metabolomics. There were 3 talks, the first was by Dr Christian Schulz from Germany who was discussing the use of analysing volatile organic compounds (VOCs) in breath samples and how they are indicative of metabolism and disease state. Breath testing for VOCs can be a screening tool for different diseases and there are various publications on developing VOC breath tests for diseases such as colorectal cancer, hepatic encephalopathy and IBD.
The second talk was by Dr Gianluca Ianiro on auto-brewery syndrome describing research that determined which microbiome profiles are likely responsible for fermentation to ethanol. This information should allow for better diagnosis of this syndrome. He reported that fungi have a significant fermentation profile, particularly *S.cerevisiae, C.glabrata, C.albicans* and *C.kefyr,* and so do klebsiella bacteria. He then explained that patients with non-alcoholic fatty liver disease (NAFLD) have a high concentration of klebsiella in their microbiome. This perhaps hypothesises that endogenous ethanol production could contribute to NAFLD pathogenesis. The aim is to further test this in liver outpatient clinics.

The last talk was by Ujjwal Mahajan from Germany on identifying a metabolomic profile for pancreatic cancer, allowing for screening of the disease via a breath test. This was achieved with the assistance of machine learning to develop a metabolic signature. However, this needs further testing to achieve validation. The science behind this session was amazing and very inspiring. It made me feel like we were at the heart of scientific innovation.

I also attended many other interesting sessions; another highlight included a talk by Dr Melanie Cuffe in the UK on her study investigating the impact of sleep on IBS. It showed that those with poor sleep had increased IBS-SSS scores and a worse quality of life. A poor quality of sleep also predicted worse bowel symptoms the following day.
One talk by Dr Jordi Serra from Spain explained the mechanisms of bloating, reporting that perceived bloating is typically due to the sensation of pressure, rather than physical abdominal distension. Patients often describe it as excess gas, but it is very rarely due to an actual increase in gas and is frequently due to abdomino-phrenic dyssynergia (if not caused by organic disease). One study of healthy controls, IBS patients and patients with neuropathy was performed where gas was infused into the jejunum. Healthy controls expelled the gas at roughly the same rate of infusion. Patients with neuropathy retained gas. Those with IBS only had minor retention but had the largest perception of bloating and the greatest objective abdominal distension.

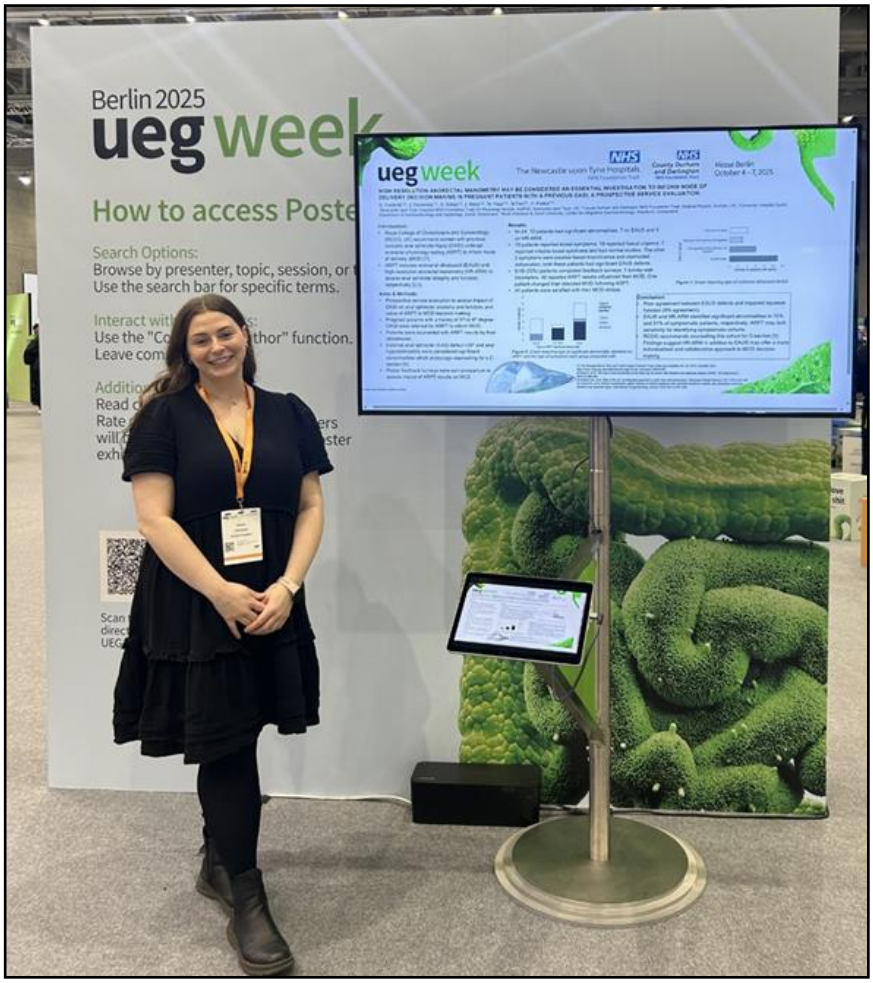
Their symptoms were also reported over a greater area of their abdomen. This suggested that patients with IBS tend to have a paradoxical contraction of their diaphragm which causes distension. One study showed that using biofeedback with an emg belt and plethysmography allowed patients to learn to control their diaphragm again. Following biofeedback, these patients showed reduced abdominal girth, improved distension scores and improved bloating. Furthermore, this effect was maintained over time. There were also other studies showing some improvement in bloating with dietary modifications and neuromodulator medications.

One other interesting talk was by Dr Dimidi from the UK and focused on the newly published British Dietetic Association guidelines for the dietary management of chronic constipation in adults (Dimidi et al. 2025). This includes a table of supplements and their impact on stool, symptoms, quality of life and their adverse events. This showed the strongest evidence across the board for magnesium oxide supplements and that there is strong evidence for kiwi fruit, which is a practical first line choice for constipation treatment.

I was very grateful to have had this opportunity to attend UEGW and would highly encourage others to attend if they have the chance to. I felt inspired after hearing about the research being performed across Europe and excited to see what the future brings in the world of gastroenterology.

References:

Dimidi. E, Van der Schoot. A, Barrett. K, Farmer. A.D, Lomer. M.C, Scott. S.M, Whelan. K. 2025. British Dietetic Association Guidelines for the Dietary Management of Chronic Constipation in Adults. *Journal of human nutrition and dietetics.* **38**(5).



Reflections of a 4th Year HSST Student

by Gemma Willis, Clinical Scientist
Mersey & West Lancs Teaching Hospitals NHS Trust

The Higher Specialist Scientist Training (HSST) programme is a five-year, fully funded training programme that is designed to prepare healthcare scientists to operate at consultant clinical scientist level in the NHS. The course combines advanced clinical training, alongside university teaching in leadership/management, specialist modules and a research project, to ultimately obtain a professional doctorate (the DClinSci). Despite the course having been available to GI Physiology applicants for many years, the number of individuals who have applied to the programme is extremely low. Whilst this may be representative of the small nature of our specialism, I wanted to put together some information in the hope of informing and inspiring potential future applicants. So, let's get into it.

When considering a place on the HSST, the first step is to put forward an expression of interest (EOI). This process aligns with the STP EOIs and usually takes place towards the end of the summer, in the year before your intended course start date. This allows time for all parts of the application process to be completed, as well as for the appropriate allocation of funding (£13,796 per trainee per academic year).

Applicants may go down the route of in-service entry (for scientists already working in the NHS, who are nominated by their employer), or through the direct entry route, (for individuals outside the current eligible workforce or those recruited specifically into the post). With HSST, the in-service posts are significantly more common, and this represents the investment of Trusts within their workforce to nurture scientific leaders.

Entry Requirements
In order to be eligible for the HSST, applicants must:

- Hold HCPC registration as a Clinical Scientist (or be able to demonstrate evidence of equivalence).
- Have at least 1 year post-registration experience.
- Align with the core person specifications in relation to values/behaviours, leadership, and research skills.

The first step in the application process is to ensure you are aware of the key dates that you need to look out for. The NSHCS publishes these dates, along with a wealth of information relating to the programme. The application form is submitted through an online portal called Oriel which you will need to register with beforehand.

The application form collects information relating to your, academic history, work experience, and eligibility screening. In addition to this, there are short-answer questions to complete about your motivation and how you meet the person specification.
If your post is through the in-service route, your application won't be shortlisted as such, but you will still be required to go through the interview process to demonstrate your suitability in relation to both professional experience and personal values.

If successful at interview, you will be offered a position and will be provided with information regarding university registration. In GI Physiology, the academic teaching is provided by the University of Manchester. The academic year starts towards the end of September and runs until the following summer. There are two semesters within each year.

HSST Training Accreditation
Once you have received an offer of a place on the HSST, you must then apply for accreditation from the NSHCS for your employing Trust, to demonstrate an ability to provide the training to the appropriate standard. This accreditation process is similar to that of the Scientist Training Programme (STP), which many centres may be more familiar with.

In order to obtain accreditation, the Trust must submit:

- A detailed application form demonstrating the experience of the hosting department, their governance and quality assurance processes and multidisciplinary connections.
- A training plan mapped out across the 5 years of the course. This demonstrates that the details of training have been considered and that there is a plan for how each element of training will be delivered.
- Contingency plans if any parts of the training cannot be completed.
- Evidence of research support and appropriate resources.

Without accreditation, the programme cannot be approved and you will not be able to register for HSST. Once all of the above is in place, however, you will be ready to begin your journey as a trainee consultant clinical scientist.

The Programme

I started the HSST in September 2021 and, (with a short pause to have a baby in between), am due to finish in September 2027. The programme is intense and demanding, but also incredibly rewarding. It's designed to take experienced clinical scientists and develop them into consultant-level professionals with the knowledge, leadership skills, and research capability to drive innovation and push forward improvements within the NHS.

The University Component

The HSST leads to the award of a Doctorate in Clinical Science (DClinSci), delivered by the University of Manchester through the Manchester Academy for Healthcare Scientist Education (MAHSE). The doctorate is divided into three sections:

- Section A – Leadership and Management
- Section B – Specialist Scientific Modules
- Section C – The Research Project

The A modules are all about developing leadership skills and professional behaviours. They combine academic theory with reflective practice, encouraging you to critically to evaluate your own leadership style and professional decisions. The workload is heavy. There is a mix of essays, self-reflective writing, presentations and teamwork, and the modules often push you to engage in activities that may challenge your comfort zone.

During the first academic year, all trainees are assigned to an Action Learning Set. This is a small group of 7–8 trainees from different specialisms. We met online at multiple points across the first year to explore some "wicked problems" that we each experienced in our workplace. The idea is to learn by reflecting, questioning, and supporting each other, and I found it to be a surprisingly enlightening process. At first the concept seemed a little unusual. However, the process of asking open questions allowed me to explore ways of thinking that maybe I wouldn't have when left to my own, familiar approaches. I actually found it invaluable for developing my ability to look at issues from different perspectives and to articulate my challenges openly — something I wasn't entirely comfortable doing at first. It was also an excellent bonding exercise and helped us to form relationships and professional networks with other trainees from different departments.

If for any reason a trainee completes only the A modules without finishing the full doctorate, the University awards a Postgraduate Diploma in Leadership and Management. If the full 5 years are completed, the credits obtained from the PGDip form part of the doctoral award.

Specialist (B) Modules
The B modules focus on advanced clinical and scientific knowledge. For GI Physiology, these modules include:

- Advanced history taking and communication skills
- Adult and paediatric practice in GI physiology
- Therapeutics and pharmacology
- Clinical measurement
- Pelvic floor disorders
- Teaching and learning theory
- Expert GI Scientific and Clinical Practice
- Leading scientific services
- Counselling
- Contemporary Issues in Healthcare Science

These units combine lectures, workshops and case-based learning to deepen both theoretical understanding and practical skills. Course materials, lecture notes, and assignment briefs are now provided on Canvas, the University's online learning platform. Discussion boards are also available, which I found surprisingly useful for troubleshooting assignments and sharing information.

The Research Component
Section C of the DClinSci is the research project, which begins in the third year and extends through to the end of the programme. This is a full doctoral-level study and should make an original and meaningful contribution to scientific knowledge.

The research must meet the same academic standards as a PhD. You are expected to demonstrate creation of new knowledge, innovation, and provide a critical evaluation of your methods and results. It's pretty daunting at first, but also an incredible opportunity to focus on something you're genuinely passionate about. Before starting, you must submit a detailed proposal for both academic and ethical approval. NHS research sponsorship and Health Research Authority (HRA) approval are mandatory, and this can take months to navigate, so the earlier you start, the better. Funding also has to be confirmed either through existing Trust resources, research grants, or negotiated support.

Assessment for Section C includes a literature review, submitted at the end of your third year, a lay presentation explaining your project to a non-specialist audience (delivered at the start of your fourth year), and ultimately a thesis and viva. The thesis can be written in a traditional or journal paper format and typically runs between 20,000–40,000 words.

Workplace Portfolio and Support
Alongside the academic elements, you must complete a OneFile portfolio that evidences competence across different areas of professional practice. This maps directly to the Academy of Healthcare Science Standards of Proficiency for Higher Specialist Scientists, and covers the following five domains of good scientific practice:

- Professional Practice
- Scientific Practice
- Clinical Practice
- Research, Development and Innovation
- Clinical Leadership

Support for the completion of OneFile is structured through three key roles:

- A Workplace Supervisor (usually a medical consultant or consultant clinical scientist) who oversees your day-to-day clinical development and signs off evidence.
- An Educational Supervisor (linked to the university) who guides your research and ensures appropriate academic progress.
- A Mentor who provides pastoral support and understands the course in detail (including the pressures of juggling it all).

Balancing the portfolio with academic assignments and clinical duties can feel overwhelming at times, particularly when life happens around it. Having a baby mid-training definitely added an extra layer of complexity for me — sleepless nights followed by early starts and essay deadlines are not for the faint-hearted (although arguably I have done some of my best work at 3am). The programme is, however, very supportive, and extensions or breaks in training can be arranged when needed.

The IAPS
As well as the viva, at the end of the course, trainees must also complete the Independent Assessment of Professional Skills (IAPS). This is a final assessment which evaluates your readiness to ready to practise as a consultant clinical scientist. It involves the submission of evidence, a presentation, a live critique of a published research paper and a professional discussion with a panel chaired by senior scientists and external assessors. The IAPS is separate from the university doctorate, it is instead, the NSHCS' way of confirming that you meet the professional standards for consultant-level practice and confirms attainment of the advanced level of clinical practice you have achieved over the course's duration.

Reflections
There's no denying that the HSST is long, intense, and can sometimes feel a little isolating. Between juggling full-time clinical work, postgraduate assignments, and family life, I've had plenty of moments where it felt like there was a mountain to climb, and I've had to really learn to manage my time properly. I've also had to step well outside my comfort zone on many occasions. Leading meetings, providing teaching, and presenting to large groups are things I once found to be a little intimidating, now they almost feel like second nature. The leadership modules in particular forced me to reflect on how I communicate and influence others and having a higher level of emotional intelligence has been hugely beneficial to my overall leadership style and approach.

Despite the challenges, I still feel like applying for the course was the best decision for me. The HSST has given me a deeper level of scientific understanding, opened up leadership opportunities, and allowed me to contribute to meaningful research which will hopefully be beneficial to our patients in the long run. It's demanding, but also genuinely enjoyable and fulfilling.

If you've ever considered HSST, I'd really encourage you to go for it. It's a big commitment, and there will definitely be moments that test your resilience, but it's also one of the most rewarding experiences and will be incredible achievement once completed. A good friend once said to me "Five years are going to pass regardless; at the end of that time do you want to say you've achieved your doctorate or that you're still thinking about it?"

Leadership opportunities in GI Physiology are so important. We're a small specialism compared to most in healthcare science, but that also means there's huge potential to make an impact and to shape service development. The HSST gives you the tools, the network, and the platform to do just that.

Are you attending a conference / event?

NewWave is always looking for reviews of GI Physiology events and meetings. If you have an event coming up and would like to submit a review (or advertise it in our next issue), please contact Gemma Willis

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