Ambulatory Care Network Meeting 2020

Introduction to the National BSGE survey

Background:

- Variability of practice and difference of women's experiences
- No agreed National benchmark
- BSGE Survey
    - Developed over one year
    - Collected existing questionnaires
    - Over 50% of Units were using the friends and family questionnaire alone
    - The draft was reviewed by the BSGE
    - The survey was then trialled in two hospitals with patient feedback
    - Finally, the survey was distributed to BSGE members and shared at the last ACN

The different elements that were important:

- BEFORE
    - Patient information leaflet
    - Pain relief
    - Choices
    - Facilities
- DURING
    - Communication
    - Shared decision-making
    - Respect and dignity
    - Experience
- AFTER
    - Knowing what to expect (results, follow-up)

There was a target of 2000 respondents – in reality we received over 5000 responses

What were people's experiences of the Survey?

- It was good timing with the queries from the hysteroscopy pain group
- Helpful, good timing
- The question that some found confusing was 'did you feel in control?'
- The staff use only section was missed as you tend to concentrate on giving the questionnaire to the patient
- I thought it would be too long(clinician) but the patients didn't seem to mind
- Patients don't seem to read leaflets
- Why don't we develop this questionnaire into an app and it could be downloaded for local purpose?
- Going forward this questionnaire should be used as a benchmark for auditing and quality checking local services.

Opinions on the questionnaire

- Overall positive
- Not taking painkillers could be a marker for people who have not read the leaflet
- Any ideas how to get people to read leaflets? It was suggested that people respond better to symbols
- The RCOG leaflet is available but the downside is that it is a uniform leaflet and it does not have local contact numbers
- When asked, over 50% of the delegates were using a post procedure leaflet
- In discussion, it was pointed out that there are no service specifications for outpatient hysteroscopy. There are no national guidelines on facilities or even the length of an appointment.
- One suggestion for improving patients taking painkillers was to include two lines on the letter for the appointment after the time and date
- In another unit where they always had a Gynae clinic before they were including details of painkillers in the clinic letter
- Another suggestion was that when you doing an electronic referral GP would have to confirm that they spoke to the patient about to analgesia
- Can we prioritise a video or a link on the Internet to more to a more realistic account of outpatient hysteroscopy compared to the negative narratives?
- Can we see if specific units were being rated as poor – this information is available
- It was emphasised that it is important to allow your patients to eat normally before an outpatient hysteroscopy
- In one unit the leaflet says 'please eat'

- Consent
    - One unit is working on a booklet that has both the leaflets and the consent in it. This idea has been borrowed from endoscopy where it is established.
    - The consent covers minor procedures
    - It was pointed out at That not all patients want to read leaflets.
    - People doing bungee jumping have been sent a video's to watch to inform consent – forms which need to be completed before the event
    - Around 10% of delegates don't use written consent
    - One delegates has moved away from written consent to verbal but does not have the facilities to offer more than diagnostic procedures at the first consultation
    - One hospital did not use to take written consent and CQC insisted
    - At the Bradford nurse hysteroscopy course they encourage trainee did to get written consent as it is difficult for a patient to deny written consent
    - It was argued in one hospital that no other procedure had a standardised consent
    - Another unit had overcome this by giving common risk factors and then stating others which would give an area to personalise risks to the patient
    - It is important to mention to the patient that they can withdraw their consent any time
    - For outpatient hysteroscopy it was suggested that you should include failure due to pain

- It was argued that we are in danger of treating women undergoing an outpatient hysteroscopic intervention like a more invasive operation which is disproportionate and too defensive. Controlling the ambienve in a room is important and there is a real danger of affecting the patient's experience.
- One hospital sends the consent to the patient before the procedure.
- One delegate stated that we do not take written consent for other routinely performed outpatient procedures such as insertion of a mirena coil or pipelle biopsy
- In reply, one delegate does take written consent because that their most serious complaint was concerned with insertion of the Mirena when they were accused of assault.

Outpatient hysteroscopy patient information leaflet

WHO modified checklist

- Human factors training is needed to explain the need for the WHO checklist to staff
- 100% of patients felt involved in their care provision after it was introduced
- 56% expected such checklists prior to procedure
    - It is now being introduced for a pipelle in GOPD
- 90% of patients said the checklist did not cause additional anxiety
- 90% of patients felt it improved patient safety
- One delegate felt there is no specifications for supporting staff. This is important because a HCA can't cover a missing swab as they are not covered by their indemnity.
- There are specifications for colposcopies as part of their quality assurance process
- People like doing hysteroscopy and part of the paperwork and bureaucracy associated with Quality assurance.
- The room was asked if they did a formal checklist…. Around two thirds in the room said yes
- Of those that did you use a formal checklist, almost all of them use the WHO checklist or a modified version.
- There is some difference in practice when it comes to pregnancy tests with some people testing everyone under 55 while the others are using the definition of post-menopause
- One delegate felt the WHO checklist is really good for team communication and they had added extra stuff such as Mirena coil insertion to act as a reminder
- It was asked if delegates use a modified WHO, could they submit their check lists to Atia so we could share practice.
- The room was asked: if you use a new checklist, do you involve the patient? The answer was an overwhelming yes
- There has been criticism in some trusts for not using the RCOG leaflet
- When asked, around 10% of the room were using the RCOG leaflet and around 10% were linking to the RCOG leaflet from their local version
- It was asked if we could set up in a shared drive for documentation such as checklists and leaflets

Video consent

- It was noted that for some banks you now have to you watch the video before you set up a new account
- The idea for video consent came from research that showed women who had a second hysteroscopy had low anxiety and pain scores second time around
- Video consent is been made. It is designed to complement medical consent information with women's voices
    - BSGE/RCOG supported
    - Barts Charity funded
    - Ethical approval granted
    - The idea is that it could be a template for other procedures
    - Collaboration with CAPH
    - It is about to recruit for workshops
- If you know anyone that would like to get involved please forward their details to: Elizabeth.Ball9@nhs.net
    - It is likely to be an animation
    - No one will be videoed…It will just be voices
- This has been successfully done for other procedures such as insertion of a Hickman line
- It was argued that hysteroscopy is complex so we would need many different videos
- It was pointed out that the British Society for Colposcopy has 11 patient focused videos which we should use as a template
- One delegate shadow experience of developing an app for mindfulness – 'we assume to patients where Digital natives but found huge barriers to downloading an app onto phones'.
- There were also concerns raised that e-consent is moving away from direct communication
- It was proposed that the video it is more about the patient experience and the aim is to demystify what is a camera, seat, stirrups, the general luck of the procedure
- One unit had already randomly selected six patients who they filmed receiving a hysteroscopy that is now shown to new patients. For the filming one camera was on the patient and the other shows the procedure through the hysteroscope.

Justin thanked industry for their contribution to the development of ambulatory gynaecology though technological innovation and specifically for their provision of staff, technologies to try and the generous provision of educational grants to support the CAN meeting.

Pain and acceptability

- DNAs are increasing problem in hysteroscopy 'they don't feel well on the day' – they are being put off by what they have heard in clinic about the procedure.
- We are not so good at telling women exactly how it feels

- There is online bias towards negative experiences and medicalised content
- One hospital is using testimonies of women who've had hysteroscopy in a laminated folder and on pin-boards of the waiting-room
- The use of music has been shown to reduce pain
    - You can use the patient's own music with headphones
    - There may also be a role for religious content
    - A 'Music bubble' can be created using pillows
    - One ear can have head phone and one ear is open to allow communication
- When the room was asked almost all says that their hospitals use music or radio

Green top guideline update

- The systematic review included antispasmodic's and TENS machine
- In the room three delegates were using antispasmodics while no one was using TENS machines
- The systematic review has suggested that a TENS machine may be beneficial
- The systematic review has shown that vaginoscopy is quicker and less painful and should be the default technique
- The systematic review as shown in the use of local anaesthetic decreases pain during or after although the message is unlikely to change due to scope sizes and older data
- The American College of Obstetricians and Gynecologists has released guidelines that says all forms of analgesia are equivalent
- No one has addressed the issue of bag pressure
- One delegate described their technique I have decreasing the pressure with the tap as they get to the cervix
- There may also be a role of fluid warming
- Another delegate stressed the importance of nursing staff talking with the patient
- Another delegate talked about the challenge of non-English-speaking services particularly with relocated patience with unusual languages
- A potential solution is the video link telephone line e.g. DORA
- One person gave their experiences of sharing images on PACS and the routine the offering the patience to see the screen

BSGE questionnaire during the procedure section

- It was pointed out that on the BSGE questionnaire, period pain was rated as worse than the average pain of hysteroscopy
- It was explained that demographic information was not put onto the questionnaire to make sure that it was anonymised
- There was some criticism of some questions
    - Do they feel in control? What does that mean?
    - Do they feel embarrassed? What are we going to do

- It was explained that these questions were included based on patient feedback. Embarrassment was a key factor that came across in the pilot phase. While the control question was to capture patients who felt vulnerable.
- These things come up again and again in patient feedback
- One delegates suggested could we ask is it more less embarrassing than a smear?
- One delegates explained that they are doing a project where they get the patient to press on a balloon as a way of determining pain.
- The room was asked who is doing targeted biopsy? Very few of the delegates are using either targeted biopsy or H-Pipelle on all patients.

Debate..is training fit for purpose

For

- The room was full of passionate people
- The new ATSM has been changed to fit with the needs of the GMC for the modern Dr:
    - Holistic approach
    - Competencies to run the service
    - Simulation training on models is now part of it
    - The importance of patient selection
    - Where appropriate, advanced procedure
- CiP1 is skills
- CiP2 is all about developing the service and developing patient information.
- NOTSS can be used for the correct decision for scope etc
- New CiPs are judged on overall performance
- Nurse hysteroscopy course
    - 18yrs ago the first nurse hysteroscopists and there has been incredible longevity of the first nurses that qualified
    - Academic and professional recognition
    - Not just about teaching technical and clinical skills but also critical thinking skills to provide services
    - Stringent assessment and mentorship
    - Current training is 50 direct cases and 100 indirect
    - Six case studies of different pathologies
    - OSCE

Against

- For the nurse hysteroscopists no one from the University goes out to assess the students
- There are no set instructions in the logbook for how many procedures are done under general anaesthetic or in the office setting
- There is no register for governance of nurses hysteroscopists
- Nurse led training tradionally did not cover prescribing or management of non-uterine abnormalities that may be detected on imaging e.g. the mangement of ovarian cysts

- For doctors, on the general curriculum there is no requirement for outpatient hysteroscopy experience
- The managerial additions take away opportunities for clinical experience
- If the service is well set up then service change opportunities are difficult to come by
- There are vague clinical requirements so you can graduate with different skills
- A lot of places who offer the ATSM don't do some of the procedures
- Every gynaecologist should be able to do hysteroscopy with some specialists who can do difficult cases
- The managerial part has nothing to do with skills it is very different
- The people in this room are not generalists they are specialists
- The curriculum is creating a generation of trainees who believe they can do hysteroscopy but can't

Vote

- Nurse hysteroscopy training IS fit for purpose
- Doctor hysteroscopy training is NOT fit for purpose

Further discussion on training

- We need to remove a nurse or doctor title
- Referring patients or treating the patients is the difference between specialist and generalist
- Doing O/P hysteroscopy needs a specialist
- Nurse hysteroscopists have more knowledge in this particular area
- Isn't it time to have quality assurance?
- Should U/S be part of the hysteroscopy program?
- Is there anything such as a generalist? ..blind procedures are still being done!
- Who supports accreditation? Slightly more of the delegates supported accreditation

Advanced training in O&G

- The latest GMC idea is to create doctors that provide quality assurance and management rather than just turn up and do things.
- Some procedures are rare in contemporary practice such as 1st generation ablation
- Because the Benign abdominal surgery: open and laparoscopic ATSM was more demanding that the Benign gynaecological surgery: hysteroscopy ATSM, the RCOG increased the demands of those performing the hysteroscopy ATSM (see Advanced Training in Obstetrics & Gynaecology Definitive Document 2019)
- O/P hysteroscopists do not need to do type 2 fibroids and it was suggested the O/P hysteroscopist and specialist hysteroscopic surgeon should be separate.
- First year consultant should have mentor.

Sharing best practice

What would you do with PMB after ablation?

- Most would hysteroscope - although most didn't think that this was a good strategy
- Strategy depends on the risk factors
- Another comment was that there is no harm trying a hysteroscopy
- One strategy is if not fit for surgery, high dose progesterone and MRI
- Alternative is high quality U/S which can assess severity and if obliterated
- One person has policy of U/S if abnormal for hysteroscopy and if the fails consider MRI or hysterectomy
- Worth asking if ablation worked if completely amenorrhoeic likely to have adhesion in low part of cavity

Ablation and/or Mirena

- Important to explain what Mirena is not ('copper coil')
- A problem with ablation is that there are late failures if patients not selected properly
- Careful counselling and patient selection is important
- Mirena first and ablation later as difficult to do the other way around
- Women often choose ablation because they don't like or want Mirena
- When asked some of the room have had difficulty removing a Mirena after ablation
- One delegate is using uterine artery embolisation to treat adenomyosis and thinks adenomyosis is under diagnosed
- We were reminded not to forget the vaginal route for hysterectomy
- The Dutch are currently doing a trial of ablation vs ablation + Mirena (MIRA 2) – Justin helped draft the protocol and is a co-applicant on the grant and looking for UK Centres if sufficient funding can be obtained
- One delegates experience was that 25% of patient have hysterectomy at 2 yrs
- Ablation can cause cyclical pain after and the Mirena might decrease pain
- There might be a slight increased risk of breast cancer with the Mirena
- When asked if the patient wanted contraception after which would you offer copper or Mirena? The majority would offer Mirena
- It is common amongst delegates that are asked to do ablation for colleagues that patients are not always appropriately referred.
- There should be a defined pathway for referrals
- The reason there was emphasis of the one-stop pathway in the new HMB NICE guidance was to ensure the patients see the right clinicians first time

Anticoagulants and hysteroscopy

- Rivaroxaban seems to be associated with HMB.
- Derby protocol splits patients into high risk and low risk. Most O/P low risk
- Primary care referrals get graded and rivaroxaban is stopped for 24 hour
- A personal experience of Apixaban is that it creates fewer bleeding problems
- One unit would not stop for any outpatient procedure
- What would you do if you had to re-categorise during a procedure e.g. large fibroid polyp?
    - Can use bedside INR
    - May not complete treatment

    - Some would not stop for diagnostic, polyp removal or ablation
- One delegate emphasised that if a patient is on therapeutic dose (for example TIA) stopping or moving to prophylactic dose is high risk

PMB

- Some scope all women on tamoxifen
- Most scope all women with an U/S appearance of polyp
- It was argued that we should have complete separation of the two week wait and benign pathway – some have no separation
- Are too many getting hysteroscopy? If incidental thickening
    - Hysteroscopy only if symptomatic
    - Or depending on thickness if 8mm or more or 11mm or more
    - Endometrial morphology is more important than ET
- About ¼ of delegates are themselves performing U/S for PMB as part of their hospitals PMB service.
- There are some efforts to link demographics to risk
- Some are using a cut off >55yrs for 2WW PMB pathway
- What would you do if there was fluid in the cavity with PMB
    - Around 50% would hysteroscopy
- How long after starting HRT would you consider it PMB? When given the options of 3months or 6 months the majority said 6 months
- If hysteroscopy was previously done how long before a repeat if a recurrence? Most would repeat after 6 months

Complications unusual cases

Presentation of sepsis and death following finding of chronic pyometria after episode of PMB (Paul Smith)

- If you diagnose a chronic pyometra in PMB
    - Who would irrigate the uterine cavity to remove purulent material? About 50% would do it. Difficult to know what is best because irrigation may spread infection to abdominal cavity
    - Who would take endometrial sample for histology? Almost all said yes. Again there may be a risk that this can introduce bacteria to blood stream.
    - Who would take a sample for microbiology? Most people would
- If the patient was well immediately after what would you do?
    - Most would let the patient home in accordance with standard practice
    - Some would observe the patient for a longer period of time
    - A few delegates would admit to hospital
- The patient is apyrexial most delegates would prescribe oral antibiotics
- Current practice following this case in Birmingham Women's Hospital: immediate IV antibiotics and extended period of observation

General discussion

- Argument for only using biopsy forceps/cup for directed biopsy
    - Should we only be taking directed biopsy and consign pipelle to non-hysteroscopists
    - Abnormalities cause clumps of cells that can be targeted
- About 1/3 of room using U/S to gain access with stenosis
- What U/S parameters do you use after pipelle?
    - You have taken a biopsy so it is irrelevant
    - Perform hysteroscopy if ET more than 4mm
- Do we need to take a biopsy?
    - Some don't
    - It was argued that hysteroscopy is good for ruling in pathology but not great for ruling out pathology
    - Others argued that you will not find hyperplasia in atrophic endometrium
    - Some would biopsy if there was recurrent bleeding.
        - In response if you have diagnosed atrophy and recurrent bleeding the patient needs oestrogen otherwise they will get recurrent symptoms
        - Some would consider MRI/hysterectomy for recurrent PMB
    - One delegate can use a pipelle without speculum using their fingers to guide them

Who does NovaSure with previous C/S?

- Typically the defect is in the cervical canal and so the thinner area will not be treated
- If there is a niche this can be seen with the hysteroscope
- 6+ C/S have been done
- Most of the room does do ablation on previous C/S

What would be the management if you perforate with anticoagulant?

- Consider laparoscopy

There should be criteria for a lead hysteroscopist through a national agenda

BSGE/RCOG need a guideline for incidental finding of increased ET

Keynote lecture

The setting

- U/S machine in hysteroscopy suite
- Screen above woman so can see her reaction easily during the procedure
- Separate screen for the woman to see
- Everything is recorded into the women's electronic notes

The story of fundal block

- 2002 started doing ablation, resection of fibromas and polyps using intracervical or paracervical block
- Intracervical block often patchy and unpredictable. It limited the group of patients that could be treated

- Uses irrigation pump (set at 60mmHg) that frees staff
- Novosure endometrial ablation
    - Timed according to cycle
    - Accompanied by partner
    - Paracervical block
    - Rescue analgesia conscious sedation
- Cyclical timing
    - Shorter treatment times
    - Shorter period of pain stimulation
    - Shortened time of vaginal discharge
- 78% asked for conscious sedation and it was difficult to schedule according to her and escorts work schedule
- Clinicians tend to underestimate pain
- The upper part of uterus innervated by ovarian plexus which led to the development of the focal local or fundal block
    - Local anaesthesia above and below the ostia
    - Allows women to drive to and from so can come unaccompanied
    - Makes booking less complicated

Biopsy

- Blind endometrial biopsy left 30-40% without tissue
- Painful with average pain scores of 6.21
- In Denmark when you remove a polyp you should take biopsy from normal looking tissue
- Miniature resectoscope for good biopsy
    - Reduce energy compared to TCRE to minimise damage to specimens
    - Pulsed electricity
    - Can take biopsy with Mirena in place
- Felypressin
    - weaker vasopressin and can be used to decrease bleeding when removing fibroids
    - can decrease intravasation/fluid absorption

What I've learnt from these 20 years

- 1x nursing staff
- Uses foot warmer from Lidl to increase fluid temperature
- All about confidence building from start to finish
    - Establish a contact
    - Building rapport – which is why he doesn't offer see and treat
    - Same doctor and same nurse for first visit and treatment
- Patient selection
    - Stay within surgical boundaries
    - Physical ASA group 1-2
    - Psychological (fear vs loss of control)
- Focused e-questionnaire before 1st visit
- They are given written information plus email

- No question left unanswered when she returns
- 'Leisurely' atmosphere
    - Woman own clothes
    - No green tiles on wall
    - No anaesthetic cart
- Doctor patience
    - Place local anaesthetic slowly
    - Cover her up while waiting
    - Wait until effective and add 2 mins
- Woman has her own monitor
- Hysteroscopist is in contact with the woman
    - Contact not distraction
    - Keen interest in more than her uterus
    - Ask if they want contact
- Telephone call by the nurse the next day and my number if there is a problem

Questions

- How much time for treatment? <30mins
- How effective is Entonox? I don't know ..doesn't use it

Polyp classification

- The majority of delegates use classification for fibroids
- According to the BSGE database we see polyps in 28% and fibroids in 6% during hysteroscopy
- Endometrial polyp classification system is being developed and everyone encouraged to take part
- Dr P De Silva will develop the polyp classification and its reproducibility as part of his PhD and using the feedback received from the ACN informed by a systematic literature review. He will keep the BSGE CAN updated and involved (?Delphi round 2).

Research innovations, hot topics and future ACN

- Campaign against painful hysteroscopy – we need to act as advocates for women who want OPH
- Should we give a mandate to Justin Clark to go to RCOG and BSGE to define quality standards

Must read papers

- Allen and Singh 2018 contraception 97 p 471-477 overview of MVA (see: DOI: 10.1016/j.contraception.2018.01.014)
- Some evidence for:
    - Pre-op NSAIDs

    - High vs low volume local
    - Buffered vs acidic lignocaine
    - Slow vs fast
    - Deep paracervical vs shallow paracervical
    - 4% lignocaine vs 1% or placebo
- No pain reduction for : lorazepam, oral opioids, Entonox, cervical prep
- Overall the message was for 20mls buffered paracervical block given slowly
- MVA data reporting severe pain:
    - Medical 24%
    - MVA 10%
    - Surgical GA 6%
    - Menstruation 10%
    - Similar between MVA and surgical GA
    - Hysteroscopy is doing better
- People may follow narratives better than numbers which is why the laminated patient testimonies may be a good idea.
- ACN collaborations – gynae mesh report we will be in the spotlight
- Goal of hysteroscopy
    - Make it less than menstrual pain
    - <4.5
    - For all procedures

Must know technologies

- Long dental syringe available
- Bridea speculum – can get vulsellum out
- Fluid management systems
    - Free nurse
    - Decrease pain
- Targeted biopsy cup
- Penthrox
    - used in A&E and by paramedics
    - inhalation anaesthetic
    - anxiolytic and analgesic properties

BSGE Nurse Hysteroscopist BSGE endorsed recommendations for acccreditation

JC Presented some slides with these recommendations (presentations to be attached with the BSGE ACN minutes)

Recommendations for nurse appraisal (see BSGE website to download)

- Activity
    - 100/yr diagnostic
    - 20/yr operative if doing
- Quality assurance

Actions:

BSGE ACN delegates to contact us via Atia Khan (BSGE secretary) [bsge@rcog.org.uk] with any additional proposed actions arising from the 2nd BSGE ACN.

All ideas listed below for collaborative development, were generated from groups discussions and individual presentations during the 2nd BSGE ACN meeting in Birmingham, UK, February 2020)

Guidance

- *Inform the Green-top guideline update*
    - Management of chronic pyometra suspected before, or diagnosed at, outpatient hysteroscopy
    - Service specifications for outpatient hysteroscopy facilities, staffing and length of appointments
    - Seek consensus on the principles of information giving (including patient information, appointment letters, e.g. improving compliance with patients taking pre-procedural analgesia).
- *Joint BSGE/BSGI guidance* for the management of incidentally increased endometrial thickness on pelvic ultrasound in a post-menopausal woman
- *BSGE guidance* for the management of abnormal uterine bleeding (including apparent "postmenopausal bleeding") after endometrial ablation?
- *Joint BSGE / BSH guidance* for the management of women taking anticoagulants undergoing hysteroscopic procedures
- *Joint BSGE / RCOG / BGCS* guideline on the management of postmenopausal bleeding

Research

- *Endometrial ablation*: Seek potential UK centres (subject to funding) for a randomised controlled trial comparing endometrial ablation with endometrial ablation + levonorgesterol releasing intrauterine system (MIRA 2 trial - https://www.trialregister.nl/trial/7817)
- *Polyp classification*: Seek the help of the ACN for future Delphi rounds; acquiring a video library of endometrial polyps with relevant demographics / histology; assess reproducibility and predictive ability of the classification
- *Felypressin*: Evaluate the role for this less potent vasopressin and can be used to decrease bleeding when removing fibroids and decreasing intravasation/fluid absorption during surgery.
- *Novel interventions to minimise pain in outpatient hysteroscopy:*
    - *Distension media* - The role of fluid warming and uterine distension (pressure, automated vs non-automated systems) remains unclear. Further RCTs needed.
    - *Transcutaneous electrical nerve stimulation (TENS*) - A recent systematic review identified this non-pharmacological, analgesic modality as potential efficacious for minimising pain in outpatient hysteroscopy

- *Music* – the role of music (type, patient selected etc.) on pain and experience of outpatient hysteroscopy
- *Penthrox (methoxyflurane)* - Evaluate the role of this portable, rapid acting, inhalational analgesic

Education and training

- *Expand Nurse Hysteroscopy training* to include areas such as therapeutic hysteroscopic interventions, medical prescribing and management of adnexal pathology detected on imaging.
- *Hysteroscopy ATSM*
  - Consider including acquiring proficiency in pelvic ultrasound
  - Review the achievability / deliverability and validity of competency levels in hysteroscopic procedures (especially the more complex and less prevalent ones).

Governance and audit

- Develop national criteria for the role of a designated lead hysteroscopist
- Establish some consensus regarding the application and content of modified WHO checklists appropriate for outpatient hysteroscopy (feed into the updated green-top guideline?).
  - ACN members to share their modified WHO checklists via Atia Khan (BSGE secretary) to establish a repository and use this as a basis to develop and share practice.
- Establish consensus for conducting pregnancy tests prior to outpatient hysteroscopic interventions (feed into the updated green-top guideline?)
- Sharing best practice
  - Set up a shared drive for documentation such as checklists, SOPs, leaflets, WHO checklists etc. from ACN members willing to share their materials
- Consent
  - Develop standardised written consent for outpatient hysteroscopic procedures
  - ACN members to help the current development of video consent for outpatient hysteroscopy
    - Any patients willing to get involved (? Sharing experience) please forward their details to: Elizabeth.Ball9@nhs.net
- National audits:
  - The BSGE has conducted audits in the last 18 months of compliance with the 2011 “Best practice in outpatient hysteroscopy guideline (GTG59)” and patients satisfaction using a standardised questionnaire with >5000 responses.
  - Compliance with GTG – this should be assessed once the updated version is completed and published (c early 2021)
  - Patient satisfaction questionnaire
    - Available on BSGE website to download or through BSGESICS (app or web) for individual units to use and compare against the national (“benchmarking”) data – these data need to be published in an accessible format on the BSGE website and a formal report

disseminated. If resources allow, attempts to be made to analyse by centre (data for individual centres only – not for dissemination)
        - Modifications needed – e.g. Do they feel in control? What does that mean?;Do they feel embarrassed?; need to separate diagnostic hysteroscopy from +/- endometrial biopsy to provide more granularity
    - Develop a new 'off the shelf' audit of the quality of outpatient hysteroscopic services using data to quality assure against recently published data from the medical literature (e.g. OPT trial; MERT trial; COAT trial; VAST trial; relevant data from the national patient satisfaction questionnaire etc.)

BSGE survey summary

- We plan to publish these data (on the BSGE website). A full report and an interpretation will be sent in due course

Attachments:

Presentations from the ACN

BSGE recommendations to support nurse appraisal

BSGESICS update