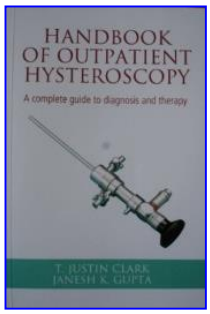
Summary report and minutes from the Inaugural Ambulatory Care Network Meeting 28th to 29th of March 2019, Birmingham, UK

Minutes from the Inaugural Ambulatory Care Network Meeting 28th to 29th of March 2019, Birmingham, UK

Day 1: Thursday 28th March 2019

Session 1: Introduction / Protocols and pathways



The aims of the meeting were set out, and in particular, the following areas: to share best practice, to discuss current challenges, to develop and learn from other centres protocols, to provide an opportunity to network and to ensure an interactive forum.

The discussion around protocols and pathways focused on postmenopausal bleeding. The increasing difficulty to provide services was highlighted due to increasing demand stop a range of different service provision set ups was apparent. The ensuing discussion included the question whether we should hysteroscope all women who screen positive on transvaginal ultrasound rather than simply performing blind endometrial biopsy. It appeared that most units represented at the meeting were using hysteroscopy + biopsy following a screen positive ultrasound. Some delegates reported using a hybrid system whereby an additional endometrial thickness threshold on scan is applied to indicate when a hysteroscopy is indicated rather than a blind biopsy where endometrial fitness cut-offs were given as 7mm, 8mm and 10mm.

Other controversies discussed included what endometrial thickness cut-off on ultrasound scan should be used to define abnormality (3mm, 4mm or 5mm) and how should we manage recurrent episodes of postmenopausal bleeding.

The question of who is responsible for two weeks wait for PMB was raised and two alternative service models were mentioned; hysteroscopists working within a diagnostic team and referring to Oncologists / MDT as part of an integrated pathway versus PMB being managed within separate oncology teams.

Another question posed was: “what do you do if the endometrial biopsy is non-diagnostic?” Practice varied amongst attendees with some automatically performing a hysteroscopy whilst others used some form of clinical correlation to decide if further testing in the form of hysteroscopy was indicated; variables to consider included the heaviness of bleeding, the number of episodes, recurrence, endometrial fitness, BMI and, other risk factors for individual cancer etc.

Good relationships with local histo-pathologists was emphasised to understand practice e.g. some histo-pathologists apparently report an insufficient biopsy if they cannot tell which stage of the cycle it is – in such circumstances the importance of speaking to the pathologist to find out if the cells were abnormal was raised. Audits of non-diagnostic biopsy rates and factors predicting them were considered a good idea particularly if rates of insufficiency were thought to be high within a department.

Pain associated with individual biopsy and costs of analysis were discussed such that the question about whether we should biopsy all women with PMB at the time of hysteroscopy was raised. Some attendees felt that biopsy should be avoided if the endometrium appeared atrophic at hysteroscopy so that the unnecessary discomfort could be avoided. However, others felt that without histopathology, cases and individual disease may be missed regardless of their hysteroscopic appearance.

The question, "should we biopsy asymptomatic women?" was posed and it was felt that generally this was not necessary but that clinical risk factors should be taken into account in addition to absolute endometrial thickness. In general, the feeling was that the evidence did not support biopsying postmenopausal women without bleeding or discharge.

Session 2: Optimising the patient experience


Information for you

Outpatient hysteroscopy

Patient experience was recognised to be a 'hot topic'. The availability of a patient information leaflet produced by the BSGE on the RCOG website was raised and most people in the room had accessed this resource.

The "Campaign against painful hysteroscopy" was discussed and Dr. M Connor (Consultant Gynaecologist in Sheffield) has been liaising with the group. It appears that their main goals are to ensure that choice regarding anaesthesia / sedation / pain relief is available to all women requiring a hysteroscopy.

Presentations during the session highlighted that 1/3 of patients who feel severe pain still feel the team were 'nice' and that a quarter of women do not read the patient information leaflet. Innovations in development include an information video /cartoons. However, what should be included needs to be considered as well as the question as to whether videos could form part of the consent process. An attendee reported that in Canada, patients are shown a video in the waiting room of what to expect.

Another question posed was, "If a woman is not having intercourse is this a contraindication to hysteroscopy?". Patient choice is highlighted, but that vaginoscopy could be offered. The possibility that some patients may be concerned about a loss of hymen if they have a GA.

The role and practice of WHO checklists was discussed: 1/3 do formal checklist; 1/3 do informal checklist; 1/3 don't do a checklist. It was reported that the CQC are asking for consent and WHO in outpatient hysteroscopy. Others reported developing a modified WHO – including contraception and pregnancy risk.

The importance of communication within the team and with the patient (patient advocates/vocal local) was emphasised to optimise patient experience and to recognise early signs of poor patient experience such that procedures could be curtailed in a timely fashion.

Tips for addressing patient choice included having a 'tick box' prior to referral or at the consultation denoting that the clinician has offered choice between GA and OP.

Work to understand why patients don't read the leaflet was discussed. A local audit conducted by one attendee showed that 50% of women don't read the leaflet – mainly due to language barriers.

Tips for improving patient experience were discussed particularly the use of low distension pressures, small diameter scopes and avoiding the use of a vagina speculum.

Methods of taking a biopsy during diagnostic vaginoscopic hysteroscopy were discussed and included the use of hysteroscopy biopsy forceps, H-pipelle, hysteroscopic tissue removal systems (formerly known as morcellators). The indication for taking a biopsy was again discussed and that any decision should be influenced by patient factors

The difficulty with evacuating fluid from the uterus using standard blind aspiration biopsy cannulas was discussed. A version of a 'pipelle' biopsy is apparently available which incorporates a syringe to get rid of residual fluid

The question "do we need to do a pregnancy test in all premenopausal women?" was supposed and the room appeared split on a vote. One attendee recounted 2 cases of pregnancy in a 51 and 49yr old patient respectively. Thus, the need for vigilance was highlighted.

The question of "how do we respond to freedom of information requests?" was raised. One view from the floor was that only information that an organisation holds electronically should be requested and that paper records are not part of this process.

Sessions 3: Clinical management

Tips and tricks discussed included:

- Ensuring that written consent included 'failure due to pain'
- Giving a patient information leaflet pre-and post-procedure
- Consider warming saline to 36.1 degrees celsius
- If you need to do bimanual do it after hysteroscopy
- Being able to move the instrument tray below the operating table for ease of access

The use of antibiotics was discussed. Few attendees used them routinely. Some units reported patients already having been swabbed for chlamydia pre-referral - in particular, fertility patients. Further questions relating to infection control were raised e.g. whether we should be using sterile gloves; It was pointed out that there is no evidence for this (and that the VAST trial where sterile gloves were not used, showed equivalently low infection rates (<3%) regardless of use of antiseptics or not), however, the counterargument was that sterile gloves should be used to help with the patient perception. The use of camera covers (no delegate reported using these routinely in the outpatient setting) and wiping the camera down in between cases (some were) were discussed.

Tips about approaches to find the cervix in patients with a high BMI were discussed and included: Vaginoscopy with or without digitally locating the cervix on vaginal examination;

positioning the patients in the left lateral position (this can avoid the large pannus protruding below and obscuring the vagina). It was suggested that we should develop an "obesoscope" with a longer shaft to aid access.

The following question were raised (responses bulleted):

Question - How should we manage incidentally thickened endometrium seen on pelvic ultrasound scan?

- Consider other risk factors
- Consider the endometrial thickness
- There should be training to interpret the ultrasound scan

Question - What do people do in women that have had a previous endometrial ablation? (particularly those that have a Novasure ablations)

- Perform a hysteroscopy and biopsy when you can
- Offer hysterectomy if there is recurrent bleeding
- Refer to MDT for discussion
- Perform an MRI and this will show if there are pockets of endometrium to biopsy or ablate
- It was suggested that you should take clinical factors into consideration e.g. age
- Repeat the ultrasound to look for change
- Perform a hysteroscopy under general anaesthetic to see adhesiolysis or ablation is possible

Question - Should we putting in a Mirena coil in at the time of ablation to avoid hysterectomy (15-20% of women have a hysterectomy by 2 years post-endometrial ablation due to bleeding or pain))?

- MIRA 2 trial will answer this and will be looking to recruit sites
- It was suggested that hysterectomy usually occurs due to pain
- Has anyone considered how difficult it is to remove the Mirena after ablation?
- Could the coil reduce the risk of cancer in high-risk patients

Question - Could I stop another consultant routinely using local anaesthetic?


BMJ RESEARCH

Local anaesthesia for pain control during outpatient hysteroscopy: systematic review and meta-analysis

- The systematic quantitative review (Cooper et al, BMJ 2011; Cochrane Review) showed no effect of topical / intrauterine local anaesthetic but cervical blocks were better. However, the studies in the systematic reviews were older using larger hysteroscopes and not vaginoscopy so not relevant to contemporary practice.

Question - What advice are people giving after hysteroscopy regarding tampons and sex?

- No specific advice offered

Question - In patients with endometrial cancer, who are unfit for a hysterectomy, are we giving a Mirena alone or a Mirena with resection of the endometrium?

- If there is focal pathology e.g. Polyp then resection should be performed
- If a global resection is performed it may be difficult to biopsy in future

Session 4: Implementing ambulatory hysteroscopy

Most delegates have a one stop PMB service, although there was debate about what a 'one stop' service entails; is it ultrasound and a pipelle clinic versus ultrasound + hysteroscopy +/- pipelle / see and treat where appropriate

Important considerations for implementing an ambulatory service were discussed and thoughts included:

- Parking
- Waiting room including temperature
- Waiting time – this can be difficult to manage if offering a one-stop service
- Use of best practice e.g. vaginoscopy
- Vocal local / patient advocate
- Analgesia: local, N_2O_2

Funding considerations discussed included:

- Business plans and emphasise new pathways / services e.g. opportunity costs such as freeing theatre time to perform more hysterectomies etc.
- Consider your audience – what will they understand about what you're doing as many maybe non-clinical
- Think about the best practice tariff
- Consider staff costs e.g. An extra HCA may cost £60 per clinic but if one extra procedure was performed it is worthwhile.

The role and future of community gynaecology settings was discussed, and the following points were made:

- Performing at the GP practice means that care is closer to home
- Better parking may be available
- It is a challenge to reduce duplication in outpatient appointments
- It was helpful to have a consultant gynaecologist to initiate a new service
- Industry was important for staff training
- Importance of patient selection is
- Barriers presented by decontamination and sterilisation
    - Use of disposable products
    - Separate sterilisation contract away from the hospital
    - Ensure 24-hour turnaround
    - Adequate transport (minimise the risk of instrument damages)
    - Contracting directly is easier than going through the hospital
- 2 to 3 months to sort out indemnity
- Importance of establishing efficient pathways between community and hospital care (some hospitals do not allow direct access from the community for secondary surgical treatment)

- Community services can be subcontracted or be a commissioned service

Tariffs. Considerations included:

- Tariffs are moving to block contracts so there may be locally agreed Terrace hope there will be a move to commissioning services or outcomes
- To increase efficiency primary care referrals will need to be improved
- There is a long-term plan to have GP or community care networks
    - This is an opportunity to develop new pathways
    - Consultant gynaecologist will need to be used in the community
- Reproductive health care is likely to come back together
    - In Sheffield they already have women's health services for women
- Block contracts
    - They can be a barrier to change
    - They are likely to commission time to see a patient or treatment
    - They will concentrate on quality of service or number of outcomes

Question - What indemnity is there for consultants going to the community?

- This may be overcome by the national GP indemnity scheme coming in
- You need to think if your indemnity is coming from the NHS or not
- Yes, it is an NHS patient and should be covered by the NHS indemnity
- The MPS provides indemnity but they will need to be notified that you're working in the community
- Check what your contract says

Question - How do you get patients to attend your community service?

- Available on ERS
- GPs refer directly
- The incentive is quicker waiting times
- There was a triage system that decided if they needed an ultrasound scan from the letter
- Local practices were engaged directly to highlight the service

Question - Why would a hospital Trust support community hysteroscopy?

- Cheaper for the trust
- Reassure that more complicated cases would be triaged
    - After triaged it is expected that those cases seen by the consultant will result in a patient being listed for surgery

Question - How were you able to justify the costs of setting up a community service?

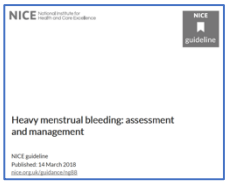
- Funds were found within the NHS England. These pockets of money can be accessed with the right business case.

The optimal stack systems were discussed - No particular advice was offered. The general consensus was that it depends on individual hospital / community unit requirements e.g. portability, size, resolution, budget

Day 2: Thursday 29th March 2019

Session 5: Keeping up to date

(Jonathan Lord)



NICE Heavy Menstrual Bleeding update guideline – This was discussed including its remit, the process and the outcomes (which can be opinion in the absence of evidence). The main headlines are:

- A care model suitable for both primary and secondary care
- Most women are seen in primary care and only need simple treatment
- Empower primary care to treat without diagnosis
- Move from ultrasound to hysteroscopy
- Restrict endometrial biopsy - blind biopsy may miss treatable lesions
- Diagnosis of structural, focal, and histological abnormalities allow focussed treatment
    - Best practice should be adopted for outpatient hysteroscopy (pre-medication, vaginoscopy, using diagnostic hysteroscopes ≤3.5mm, see and treat services). Local data was presented showing that the pain intensity is approximately the pain level of menstruation, although two thirds of patients have pain less than menstruation.
- Surgical options have been upgraded to first time which can be pointed out to your local policymakers (easy access to surgical treatment if persistent heavy menstrual bleeding or the patient does not want pharmaceutical treatment)

Rapid access referrals for abnormal bleeding – emphasised that inspection of the vagina and cervix is needed; vaginoscopy can be used - to inspect the vagina and cervix and there are hysteroscopes with a microscopic camera being developed to inspect cervical lesions

Important recent papers of interest to the ACN were presented and included:

- Green top guidelines in hysteroscopy

- NICE guideline for HMB

- Smith. Vaginoscopy Against Standard Treatment. BJOG (https://obgyn.onlinelibrary.wiley.com/doi/pdf/10.1111/1471-0528.15665)

- Smith. Morcellation versus Electrical Resection. Green Journal

- Cooper. Cost effectiveness of diagnostic strategies for management of abnormal bleeding. Health Technol Asssess

- Shapley. The epidemiology of self-reported intermenstrual and postcoital bleeding in the perimenopausal years. BJOG

- Pennant. Premenopausal abnormal uterine bleeding and risk of cancer BJOG

- Van Hanegem. Diagnostic workup for PMB RCT BJOG

- Skensved. 2012 gynecol surg and Kumar 2016 fertil and steril fundal block
    - Is the difference between pain scores due to higher volumes of LA and longer time before the procedure starts?

- BSGE /ESGE guideline on management of fluid distension media in operative hysteroscopy [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5133285/]

<u>Relevant major research studies findings coming up</u>

- MIRA trial results (Mirena vs. NovaSure ablation)
- HEALTH trial results (Laparoscopic subtotal hysterectomy vs. endometrial ablation)

<u>Widening the concept of ambulatory care</u> - from outpatient hysteroscopy (tissue removal / ablation etc.) to early pregnancy and gynaecology care (Manual Vacuum Aspiration – MVA; Bartholin's cyst incision (Word catheter); Urogynaecology (Cystoscopy/bulking); Role of IV sedation

Session 6: Training

Mary Connor made a call for hysteroscopy images to be incorporated into the RCOG diagnostic and operative hysteroscopy handbook. The deadline is 18/4/19.

<u>Training courses</u>

- ATSM
- RCOG approved hysteroscopy course (next one is Sept 24th)
- GESEA exams (HYSTT 1 &2)
- Company led teaching for specific equipment
- MATTU course
- Lamb heart and potato models and simulation training
- Nurse hysteroscopy training

<u>Nurse hysteroscopy training</u>

- New programme lead at the University of Bradford
- 10-day course
- Important to have trust support for nurses before they come on the course and after
- ? need for nurse conference
- Contact the Bradford team if there is anything you want to add to the nurse hysteroscopist course, so the nurses are better prepared to provide care in hospitals

<u>How do we make training better? -</u> Results of break out groups:

- Training network

    - Centres that offer training
    - Useful tips
    - Link to Deanery training programme
- Develop more realistic model/kit to train vaginoscopy
    - There was interactive programme for difficult ESSURE cases that could be used as template
    - BSGE have bought models and are available for units to borrow
    - New, higher fidelity training models / systems
- Need to consider if we have indemnity if the only training is industry training.
- No pay band standardisation for nurse hysteroscopists across trusts
- Nurses hysteroscopy
    - Consider advanced gynae nurse training
        - MVA training
        - Postmenopausal issues e.g. cysts
    - Address rota gaps for junior doctors
    - Ongoing support after initial training
    - Support for study leave particularly for nurses
    - Set curriculum that is harmonised for both nurses and doctors
- Allocate time for training
- Minimum background knowledge before starting
- Dexterity test
- Decide whether competence is based on assessment or number of cases
- Teaching on communication and non-technical skills
- Address teaching at the level of the curriculum - ambulatory care should be embedded into the curriculum

Session 7: Quality assurance

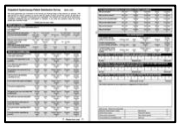
The following pieces of work were discussed: A national audit of compliance with guidelines for best practice in outpatient hysteroscopy, a national, standardised patient satisfaction questionnaire for benchmarking, updating the Green Top "Best Practice in Outpatient Hysteroscopy" guideline and the BSGESICS ("Surgical Information Collection System").

National audit of existing services showed:

- 97% use leaflets
- 88% recommend NSAIDs
- 5% oral opioids
- 60% do pregnancy test as standard
- 77% have written consent
- 72% routinely offer a choice of GA vs OP
- 42% routinely do vaginoscopy
- 18% do blind D&C
- 56% give LA for diagnostic
- 61% give LA for operative

Patient feedback questionnaire

- Development of standardised feedback questionnaire
- Reviewed existing questionnaires
    - From BSGE members
    - Found electronically
- Current questionnaire tested in clinic with patient feedback
- Key themes:
    - Before
        - Knowing what to expect
        - Pain relief
        - Know choices
    - During
        - Communication
        - Shared decision
        - Respect dignity
        - Experience
    - After
        - What follow-up
        - Results
- Plan to put questionnaire on the BSGE website
- Focus groups before uploaded
- Perform national data collection this will provide a data standard for practice
    - Months of June or September / October (based on a vote) suggested for a national audit to gain data we can use for benchmarking – delegates and BSGE members will be emailed
    - Add the standardised patient satisfaction questionnaire to the BSGE website and BSGESICS



- If you get a complaint you can use the data to defend your practice/service
- The data can be used for annual reviews and CQC

Can we validate the questionnaire?

- Concerns that wording could influence the results e.g were you respected? vs did you feel disrespected?
- Psychometric testing and validation would be necessary
    - Potential research area
    - Opportunity to develop into patient reported outcomes
- Other questionnaires have had the language modified to the level a 9 year old child would understand

What are the plans for data entry at national level?

- It will be available on the BSGE website/ BSGESICS
- Baseline data nationally
    - Every single woman in clinic
    - Anonymous

- The database will generate mean scores so you can check your practice and if an outlier can identify local factors e.g. technique, large scope, written vs. informal consent etc.

Governance - How can we identify failing centres?

- It was recognised that as a group it damages our reputation
- If we engage with hysteroscopy action can they highlight poor centres
- We need to highlight problem centres and survey can act as a benchmark
- If you're an outlier is it a recurrent problem or a one off
- How do we reach these groups if they aren't engaging?
- In Canada HCA is PALS trained and they engage with every patient that has a failed procedure.

Updating Green Top "Best Practice in Outpatient Hysteroscopy" guideline

- Why do we think there is not uptake of recommendations in some units?
  - Funding is biggest barrier
  - Too many referrals with system to cope with
  - We need to add caveats about size of scope +/- biopsy
  - Everyone at the meeting was using best practice
- What should we do about people practicing with minimal training?
- Accreditation as marker of quality, but is it more of a burden vs helpful?
- It is a lot of work maintaining accreditation for colposcopy
- We could do it for the centre rather than the individual like BSGE endocentres:
  - Based on audit of results
  - Services provided
  - Opt in system
- Accreditation might allow the opportunity to ring fence more resources in our trusts

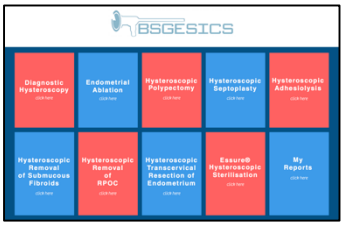
Proposed format of RCOG/BSGE Green Top Guideline:

- Will address both diagnostic and therapeutic outpatient hysteroscopy (2011 guidance restricted to diagnostic)
- New sections include:
  - Patient information and counselling
  - Instrumentation
  - Prevention of infection
  - Documentation
  - Training requirements and standards

Is there any work on women who want to have outpatient hysteroscopy?

- The OPT RCT had an association patient choice study
- The same work also had a qualitative analysis

BSGESICS



- You can access this on the BSGE website / google player
    - App on iphone imminent
- Secure cloud-based system, which is double encrypted
- Laparoscopic update due soon
- Can access on phones, tablets and NHS computers ('NHS safe')
- Remembers the most used data and pre-fills in form
- Additional information and person performing procedure (useful if training) have been added
- Can generate an op note
    - Send to your NHS email
    - Send to your junk mail and it will naturally delete after 10 days
- Can generate reports and export as excel file
- Audience asked for a way of recording if women referred for hysteroscopy but didn't have one because it wasn't needed e.g. Mirena fitted without hysteroscopy

Session 8: Research

The following areas of research were discussed: The VAT RCT, relevant NIHR HTA Commissioned Calls, Proposal to use the ambulatory care network to generate and deliver relevant research, development of an endometrial polyp classification system, and core outcome sets in heavy menstrual bleeding and hysteroscopy.

VAST study

- Vaginoscopy should be considered as the default technique
- No difference in infection rates between vaginoscopy and standard technique
- Nearly 1:5 women get pain for a couple of days after the procedure

NIHR commissioned calls

- Treatment of polyps and fibroids for fertility
- Hysteroscopic treatment of postpartum retained products of conception
- Dutch 'NIHR' Zon MW – "MIRA2" endometrial ablation + Mirena vs. Endometrial ablation alone

Proposed ambulatory research network

- Prioritise hysteroscopy research
- Generate questions
- Collaborate for grant applications
- Recruit to funded trials in hysteroscopy

Proposal for development of a polyp classification system

- We will need a photo of polyp (possibly a short 1 minute video)
- Some clinical information (risk factors for sinister pathology e.g. BMI, age, presentation)

- We will then ask people to describe the polyp without the history or pathology
- Discussion:
    - Technology in some trusts may not allow them to send photos
    - Suggestion to take picture on phone
    - GMC allows intra-abdominal/pelvic photos or videos as there are no identifying factors
    - A confounder will be the stage of the cycle in premenopausal women
- Aim would be to discriminate atypical (malignancy / pre-malignancy) or typical (benign / non-atypical hyperplasia) at a minimum.

The audience (in groups) were asked to come up with as many ways as possible to describe endometrial polyps. The exhaustive list of features included:

- Cornual
- Smooth
- Irregular
- Vesicular
- Anterior
- Posterior
- Lateral
- Fundal
- Lower segment
- Broad based
- Pedunculated
- Fibroid polyp
- Necrotic
- Friable
- Calcified
- Multiple
- Suspicious
- Haemorrhagic
- Prolapsing
- Cervical
- Infected
- Degenerating
- Sessile

Core outcome sets for hysteroscopy:

- Bare minimum set of outcomes for research
- Allow data synthesis and reduces outcome reporting bias
- Can also have scale and timing
- CROWN initiative
- Need to collaborate to develop scope and consensus (through Delphi study)

Core outcome set for HMB

- Core outcome set being developed
- Close to Delphi survey stage

- Please look out for email and complete all the rounds

Closing thoughts and thanks

- Please provide feedback for any future ideas
- Do we want to expand the scope of the meeting to include other aspects of ambulatory care e.g. MVA or restrict to hysteroscopy
- When and where do you want future meetings
- Thank you for attending

Proposed ACTIONS arriving from the proceedings of the Inaugural Ambulatory Care Network Meeting 28th to 29th of March 2019, Birmingham

Actions

1. Develop and validate a post-menopausal bleeding diagnosis and treatment pathway to include the role of outpatient hysteroscopy and endometrial biopsy (including dealing with non-diagnostic endometrial biopsies), and the management of recurrent post-menopausal bleeding

2. Share best practice regarding patient information, to include innovative ways of delivering information and ensuring that women get access to a range of resources and use them.

3. Develop guidance regarding minimising infection (e.g. technique, when to take genital tract swabs, administer antibiotics, use of sterile gloves, camera covers etc.).

4. Develop guidance regarding avoiding outpatient hysteroscopy in potentially pregnant women (e.g. universal testing vs. targeted testing, information, WHO check-lists etc.)

5. Develop guidance regarding how to respond to freedom on information requests

6. Develop guidance regarding outpatient hysteroscopy in obese women

7. Develop guidance about the management of incidentally thickened endometrium detected on pelvic ultrasound scan?

8. Develop guidance about the management of bleeding after an endometrial ablation

9. Members to contribute through peer review of an upcoming update and expansion of the BSGE/RCOG Green Top Guideline “Best Practice in Outpatient Hysteroscopy” to include therapeutic procedures

10. Develop guidance about implementing ambulatory hysteroscopy in hospital and community settings including example business plan templates

11. Develop a strategy for influencing tariffs / funding for outpatient hysteroscopic procedures

12. Widen the concept of ambulatory care - from outpatient hysteroscopy (tissue removal / ablation etc.) to early pregnancy and gynaecology care (Manual Vacuum Aspiration – MVA; Bartholin’s cyst incision (Word catheter); Urogynaecology (Cystoscopy/bulking); Role of IV sedation; colposcopy; infertility (egg collections etc.). Consider writing a series of articles or textbooks.

13. Develop nurse hysteroscopy training; updating the current educational provision and providing support through educational / training / audit resources to support accreditation

14. Improve simulation training utilising the latest high-fidelity simulators / models

15. The following pieces of work were discussed: A national audit of compliance with guidelines for best practice in outpatient hysteroscopy, a national, standardised patient satisfaction questionnaire for benchmarking, updating the Green Top "Best Practice in Outpatient Hysteroscopy" guideline and the BSGESICS ("Surgical Information Collection System").

16. National audit of patient experience: Disseminate the BSGE standardised patient feedback questionnaire for outpatient hysteroscopy – a national audit each year (2019) and link on the BSGE website and BSGESICS

17. Develop guidance about governance and in particular helping centres with suboptimal outcomes recognise this and rectify the situation

18. Encourage the use of the BSGESICS resource; analyse the data for benchmarking and disseminate through the BSGE

19. Encourage participation of ACN attendees / BSGE members in funded (e.g. NIHR) multi-centre research

20. Develop a formal ambulatory research network with the aims of prioritising hysteroscopy research, generating research questions, collaboration on grant applications and recruitment to funded trials in hysteroscopy

21. Support a project to develop an endometrial polyp classification system including asking attendees / BSGE members to contribute to the project including provision and / or assessment of endometrial polyp photos / videos

NEXT MEETING: BIRMINGHAM HYATT HOTEL, BIRMINGHAM, UK 27-28 FEBRUARY 2020