Royal College of Obstetricians & Gynaecologists

Pain Relief and Informed Decision Making for Outpatient Hysteroscopy

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This is the first edition of this guidance.

Within this document we use the terms woman and women's health. However, it is important to acknowledge that it is not only people who identify as women for whom it is necessary to access care. Gynaecology and obstetrics services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

1. Purpose

This guidance has been written for healthcare professionals who are involved in providing outpatient hysteroscopy (OPH), with the aim of optimising a woman's experience and clinical outcomes.

2. Introduction and background

Hysteroscopy is a common and valuable intervention to diagnose and treat gynaecological conditions arising in the uterus. Most women describe a positive experience of hysteroscopy, with levels of discomfort acceptable to them, rapid recovery and avoidance of the need for a general anaesthetic. However, it is important to recognise that hysteroscopy can cause severe pain and be traumatic for women. This is difficult to predict. Therefore, units need to share with women clear, accurate and relevant, written and verbal information. It is of vital importance that women feel they can make informed and authentic decisions and choices. These should include whether they want to proceed with a hysteroscopic procedure and if so, their preferences for treatment setting, pain control and type of anaesthesia. It is also important to acknowledge the variety of practices and facilities within the field. Units need to match against a woman's preferences, which may necessitate referral to another colleague or an alternative hysteroscopy unit with additional facilitates or pain control measures.

This Good Practice Paper will outline what a good OPH service should look like in order to achieve the optimal clinical and psychological outcomes for women.

3. Before the procedure

3.1 Communication

At the time of arranging the OPH appointment, units should ensure women have been sent an information sheet and/or access to online resources that meet the Royal College of Obstetricians and Gynaecologists (RCOG)/British Society for Gynaecological Endoscopy (BSGE) standards.[1] This pre-procedural information should include up-to-date local contact details for the unit (telephone number and/or email address) so that women can get in touch with any questions or concerns prior to their attendance. This information should also include a recommendation to take simple analgesics such as ibuprofen and/or paracetamol at recommended doses, unless contraindicated, 60 minutes before the scheduled appointment.

The information provided should cover 'see and treat' (see section 3.3) where additional diagnostic or concomitant therapeutic procedures can be conducted immediately following initial diagnosis.

Prior to the procedure the hysteroscopist must see the woman in a private consultation area and give her the opportunity to ask any questions and to raise any concerns. Specifically:

- Listen to the woman, and explore and address any concerns she might have about the procedure, including any questions about pain management.
- Ensure the woman has all the information she needs to enable her to make decisions in clinic.

If a woman attending her appointment is unaware that she has been referred for an OPH, then she should be given the opportunity to reschedule the hysteroscopy after being given written and verbal information, once she has had time to consider her options. Similarly, any woman who is unsure whether she wants to proceed with an OPH should be allowed more time to make a decision and offered a further appointment.

3.2 Informed decision making

The clinical team should be mindful of the fact that arrival of the woman at the clinic does not imply she has given her consent for the procedure.

The hysteroscopist is the responsible clinician and must be reassured that the woman has had sufficient information to give informed verbal and/or written consent (please refer to the forthcoming Getting It Right First Time (GIRFT) *Outpatient hysteroscopy consent form* and *Outpatient operative hysteroscopy consent form*).[2,3] Specifically, she should understand the reasons for the procedure and what it entails, any additional procedures that may be necessary, possible adverse effects, and the benefits and risks compared to alternative options other than hysteroscopy. A copy of the written consent form should be provided along with relevant patient information prior to the procedure.[4] The woman should be made aware of other settings and modes of anaesthesia for hysteroscopy as well as alternative care options available to her, and on the day of the procedure be given enough time to discuss any concerns or to change options. It is best practice for each unit to give their own outcomes in written information (e.g. patient satisfaction, pain comparators, likelihood of choosing the same procedure/unit in the future).

Importantly, the hysteroscopist must remind the woman that she is likely to experience period-like cramping and lower abdominal pain during and after the procedure, and that should she find the procedure too painful or distressing she should notify her clinical team who will stop the procedure immediately. It is important to ensure an environment where the woman and/or team member feel empowered to be able to ask for the procedure to be stopped at any stage. If the hysteroscopist, with or without feedback from the clinical team, decides for other reasons to abandon the procedure in the best interest of the woman, this should be communicated to the woman immediately.

The procedure should be rescheduled if the woman feels she needs more time to consider her decision, especially if she has not received or read any relevant patient information prior to attending.

Some women may consider receiving intravenous sedation or general anaesthesia before the procedure a better option. In this case, the woman should be made aware that few units currently offer sedation in an outpatient setting and that post-operative pain may not be any less. She will need to balance the advantages to her of being asleep or sedated from an awareness and procedural pain perspective against the disadvantages, which include the need to be admitted to hospital and fast before the procedure, the risks associated with general anaesthesia and intravenous sedation and prolonged recovery relative to an outpatient procedure.

3.3 See and treat

Where possible and acceptable to the woman, the process should aim to be 'one-stop', which means she is cared for efficiently in a single clinic visit. To facilitate this, a 'see and treat' approach should be adopted where appropriate. The woman should be offered concomitant procedures, such as endometrial biopsy, insertion or retrieval of intrauterine devices (IUDs), cervical or endometrial polypectomy, removal of submucosal fibroids and division of minor adhesions. Prescriptions may also be given for any recommended medication.

Any anticipated additional procedures that may be necessary should be discussed with the woman by the responsible clinician prior to starting the diagnostic hysteroscopy. She should be made aware by her clinician that she can choose to defer a therapeutic procedure following diagnosis, and be given time to consider if and how she wants to undergo the therapeutic procedure in the future.

3.4 Safety checks

Use of a checklist (e.g. a specifically adapted World Health Organisation [WHO] surgical safety checklist or a locally developed outpatient procedure safety standard checklist) is recommended. This is to make sure essential elements such as patient identity checks and pregnancy tests are recorded where appropriate and any medical concerns identified.

Pregnancy should be excluded in women of reproductive age. As a minimum these women should be asked about the timing of their last menstrual period and any history of unprotected sexual intercourse. A urinary pregnancy test should either be undertaken routinely in women who are premenopausal and sexually active, or based upon the timing of their last menstrual period and history of unprotected sexual intercourse.

3.5 Environment

It is important to create a relaxed and reassuring outpatient-based environment to reduce anxiety for the woman.

Dress/uniform is at the discretion of each team member with the aim of portraying a caring, professional environment while being comfortable (e.g. wearing scrubs, uniform, clinic-based office clothes depending on preference).

The clerical and clinical team must ensure the highest standards of professionalism are delivered consistently, for example, offering a friendly greeting, ensuring everybody introduces themselves or is introduced and not appearing rushed.

The provision of privacy, dignity and comfort for the woman must be a priority when undertaking an intimate and potentially painful examination. It is important to provide a private changing area with easy access to a toilet and to conduct the procedure in a private, enclosed clinic area where no additional staff can enter once the woman begins to be positioned upon the operating couch. Time must be taken to pay attention to positioning women in the correct way to facilitate the OPH ensuring the comfort of the woman at all times. Women should never be unnecessarily exposed (e.g. through the use of a drawer sheet over the patient's knees) and clinicians should avoid prolonged discussions about the clinical findings and care options with the woman at the end of the procedure until they are fully dressed and sat next to the clinician in a private consultation area.

3.6 Advocacy for women

The woman should be offered support through explanation, reassurance and conversation if they wish. The best way of achieving this is to have a dedicated member of staff, usually a healthcare assistant (HCA). If the woman wishes a partner or friend to be present and advocate for her then this wish should be accommodated. The primary responsibility of any

chosen advocate is to provide these supportive measures and alert the hysteroscopist about any concerns, especially any adverse experiences she may have such as emotional distress, feeling faint or significant pain. Attention must be paid to the comfort of the woman and additional supportive measures such as provision of a fan, water, a blanket or pillow as appropriate. Provision of a heat pad or warming the instilled saline to body temperature should be considered to provide more comfort.

The patient advocate must instruct the hysteroscopist to stop the procedure at the woman's request or if they consider this is in the woman's best interests because of undue distress or pain. If appropriate, other options for pain control should then be offered such as local anaesthesia or inhaled sedation/analgesia or a decision made to abandon the procedure and then reschedule the hysteroscopy using a different mode of pain control, namely intravenous sedation, regional or general anaesthesia or consider alternative options for ongoing management.

3.7 Information about pain control

Units should have the skills, equipment, experience and local patient-reported outcome measures to be confident that the majority of women will not require any local anaesthesia for a diagnostic hysteroscopy, and that the pain should be no worse than that experienced in natural menstruation. Clinicians should make the woman aware that the way the nerves supply the cervix and uterus makes it impossible to fully anaesthetise the uterus with local anaesthetic and so period-like pain is to be expected. The woman should have been advised (see section 3.1) to take simple analgesics such as ibuprofen and/or paracetamol, unless contraindicated, 60 minutes before the scheduled appointment. If she has not taken over-the-counter simple analgesics but now wishes to, then such analgesia should be administered, otherwise the option to reschedule the procedure should be offered. Where local anaesthesia is warranted, the woman should be informed that the process of injection can cause transient pain. Use short-acting local anaesthetic agents that do not contain adrenaline to prevent unpleasant adverse effects such as palpitations and a feeling of anxiety.

Inhaled analgesia (e.g. nitrous oxide/oxygen mixture) should be available provided appropriate ventilation is available and the woman has no medical conditions contraindicating its use. It can be used when pain is anticipated, such as when placing local anaesthetic, or during the procedure where the patient requests an adjuvant.

It is important to provide women with a clear idea of what is involved with OPH and the type of pain they might experience; the procedure is short, the pain could be similar to the pain experienced during a menstrual period and most women find the procedure acceptable. The woman should be informed that some women find the pain severe and if this is their experience, the procedure must be stopped. She has the right to request this at any time and the procedure will be stopped immediately. Women should be informed that one-third of women rate the pain associated with OPH at 7 or more on a pain scale out of 10, but they should also know that acceptability/satisfaction rates are consistently well above 90%, which probably reflects the brevity, safety and convenience of the procedure.

In general, women should be advised that a diagnostic procedure itself takes around 3 minutes on average and most operative procedures (e.g. polypectomy, removal/insertion of IUDs, lysis of filmy adhesions, endometrial ablation and removal of small fibroids) take between 5 and 15 minutes. Quoting pain scores in isolation is of limited value when counselling women because of difficulties with generalisability and also the lack of context in terms of acceptability, satisfaction and preferences (e.g. safety, immediacy, relative brevity of the procedure(s), fear of hospital admission, and avoidance of risks associated with general anaesthesia and intravenous sedation, etc.). Where possible, comparisons are more intuitive – for example, that pain is usually of a similar severity to that from menstrual cramping.

If women request information about pain scores or if clinicians feel discussing these scores useful in their counselling of women, then it is important to provide context to aid a woman's informed decision making. The average pain score for

women undergoing the commonest hysteroscopic procedures (diagnostic +/– biopsy, endometrial polypectomy) in the UK is 5.2/10; in the same group mean pain reported from menstruation is 5.5. Although one-third of women reported pain scores of 7 or more out of 10, the rates of acceptability and preference to have an outpatient procedure if a hysteroscopy was required in the future exceeded 90% and 93% respectively in this subgroup of women recording the highest pain scores, inferring that pain itself is not the main factor in their decision making.[5]

4. During the procedure

4.1 Resources

The OPH service should be appropriately sized, equipped and staffed. Healthcare professionals should have the necessary skills and expertise to carry out diagnostic and/or therapeutic OPH.

The team should be adequately staffed to allow one member of the team to act as the patient advocate i.e. be exclusively dedicated to looking after the woman's immediate needs and overall wellbeing rather than concentrating on the technical elements of the procedure.

4.2 Advocacy for women

The procedure should be stopped if the woman or the clinical team observe any adverse experiences such as emotional distress, feeling faint or significant pain (see section 3.6). Other options (e.g. local, sedation or general anaesthesia) should then be offered. Attention should be paid to minimising the woman's exposure during the procedure, e.g. using drapes or a drawer sheet.

4.3 Technical aspects

Vaginoscopy should be the standard technique for accessing the uterine cavity using the smallest diameter diagnostic or operative hysteroscopes (instrumentation chosen according to the nature of the hysteroscopic procedure).[6] Diagnostic hysteroscopes should be 3.5 mm or less in outer diameter (up to 4.5 mm to facilitate directed biopsies), operative hysteroscopes 5.5 mm or less. If using a bespoke hysteroscopic tissue removal system (HTRS), then the smallest diameter system available, appropriate for the procedure, should be used.

The choice of hysteroscope (e.g. flexible or rigid; 0° or fore-oblique distal lenses) should be left to the discretion of the operator.

Normal saline should be used routinely as the distension media; consider warming the saline to body temperature.

Routine use of a speculum with or without cervical instrumentation and blind cervical dilatation should be avoided.

Hysteroscopic removal of endometrial polyps should be performed using small diameter HTRS in preference to conventional, miniature mechanical instruments or miniature electrodes unless the lesion is solitary, pedunculated, small (typically 1 cm or less) and non-fundally located. This is because HTRS are more effective at removing polyps, quicker and associated with less pain and greater acceptability than electrosurgical techniques in an outpatient setting.

Blind global biopsies can be used to gain a good sample where there is generalised endometrial change. However, biopsies should be targeted under direct vision using hysteroscopic biopsy forceps where focal pathology is identified or where the use of a vaginal speculum is not possible or desired in the presence of a uniform endometrial appearance.

The lowest possible fluid distension pressure should be used to obtain an adequate view. This can be achieved by:

- Use of automated fluid management systems, e.g. setting initial intrauterine pressures at 40–50 mmHg and increase to the maximum needed to obtain a satisfactory view.
- Manually instilling fluid via a syringe and titrating distention.
- Titrating inflow using the tap on the inflow channel (and/or outflow channel if a continuous flow hysteroscope).
- Using continuous flow via a gravity feed or external compression, although care needs to be taken to ensure initial pressure is kept low and that it is maintained to ensure the view is adequate.

4.4 Involvement of women

The woman should be informed that they can watch the screen if they wish. Communication with the woman by the hysteroscopist and/or member of the nursing/HCA staff during the procedure is to be encouraged unless the woman expresses a desire not to be informed. The clinical team should also be aware that a woman may change her mind during the procedure about her wishes regarding the receipt of procedural information and her real time wishes should be respected.

It is particularly important to warn the woman of unusual or potentially painful sensations so they are prepared and not alarmed, e.g. initial touching of the genital area with the hysteroscope, instillation of fluid, passage of the hysteroscope through the internal cervical os (usually a sharp or sudden cramping pain for a few seconds), injection of local anaesthesia (usually a sharp, stinging sensation lasting a few seconds), etc.

4.5 Data recording

Images should be captured of the uterine cavity to demonstrate anatomy (e.g. panoramic view of the cavity, magnified views of the tubal ostia/cornual regions, fundus, uterine walls, cervical canal and cervix) and any endometrial or structural pathology (e.g. global endometrial appearances such as vascularity, thickening, irregularity, necrosis; focal endometrial lesions, vascular polyps, fibroids, adhesions, congenital uterine anomalies, embedded coils, etc.).

The sound length (distance from the uterine fundus to external cervical os) should be recorded when a global biopsy is taken or an IUD fitted.

Hysteroscopists should also consider recording pain scores as part of the clinical record of the procedure, and ensuring that their own patient-reported outcome measures are benchmarked against published data.[5]

4.6 Concomitant procedures

It is advised to only take an endometrial biopsy if there is a strong clinical indication (see NICE guideline *Heavy menstrual bleeding: assessment and management* [NG88]).[7] Directed, hysteroscopic biopsies should be used for focal lesions. Representative hysteroscopically-directed biopsies can be taken in the absence of focal pathology.

4.7 Local anaesthesia and sedation

Standard protocols regarding the type, maximum dosage and route of administration of anaesthesia should be implemented. Local anaesthesia using short +/– medium-acting agents should be given using a four quadrant cervical block (intracervical or paracervical), or a combination of paracervical and intracervical. This should be administered if the cervical canal needs dilatating to access and instrument the uterine cavity.

Topical anaesthesia may be applied to the ectocervix to facilitate cervical instrumentation. Short-acting topical anaesthetic agents can be instilled into the uterine cavity via a cannula or using the hysteroscope. Intrauterine fundal/cornual blocks may be considered for operative procedures.

Inhaled analgesia (e.g. nitrous oxide) may be made available for part or all of the procedure, provided there are appropriate facilities and the woman has no conditions contraindicating its use. Intravenous conscious sedation should not be routinely used for outpatient hysteroscopic procedures in the absence of data supporting acceptability, effectiveness and safety. See references 8 and 9 for evidence summaries.

4.8 Communication

Encourage the woman to talk to you and the team during their procedure to allow the team to employ pain reducing strategies. It is important to recognise that the operating carer may become task focussed and unaware of the woman's feelings. Ensure a team member is always available and responsible for observing the woman's behaviours, asking if she is okay and whether she is in any pain, and responding to her needs.

If further procedures are necessary, discuss this with the woman so she can decide whether she wants to proceed. At all times during the hysteroscopy, including any additional procedures that may be undertaken, the woman should clearly understand that she can ask to have the procedure stopped immediately.

4.9 Clinical and technical tips for reducing or mitigating pain during the procedure

Organisation	Ensure the woman receives written information, including clear details on what to expect, prior to the appointment. This should include the advice to take oral analgesia 60 minutes prior to the appointment. During the whole appointment, ensure the highest levels of professionalism are delivered – e.g. all staff introduce themselves, attention given to maintaining dignity (private changing facilities, use of drape or drawer sheet to minimise exposure, clear written information given at discharge), offer of one-stop process (i.e. care provided in a single clinic visit where appropriate). Units should collect patient-reported outcome data, benchmark themselves against published norms and strive for continual improvement. Units should be suitably equipped (e.g. small diameter diagnostic and operative hysteroscopes, adequate fluid management systems, suitable treatment couch, etc.)
Communication	Warn the woman in anticipation of unusual or potentially painful sensations so that they are prepared and not alarmed e.g. initial touching of the genital area with the hysteroscope, instillation of fluid, passage of the hysteroscope through the internal cervical os, taking a global endometrial biopsy, insertion of an IUD, injection of local anaesthesia, initial activation and touch with electrodiathermy, etc. Keep the woman informed of progress and findings if they wish, but without prolonging the procedure.

Minimise touch and trauma to the genital tract and uterus	Conduct slow and careful progression of the hysteroscope. Pay attention to ensure the axis of the hysteroscope is in line with that of the cervical canal. This requires an appreciation of the angle of the distal lens and the hysteroscopes orientation. When using an oblique ended hysteroscope, rotate the hysteroscope 180° so wide diameter of the hysteroscope approximates the elliptical transverse axis of the internal cervical os. Ensure gentle and precise manoeuvres when removing focal lesions to avoid unnecessary noxious stimuli to surrounding tissue such as the myometrium.
Minimise the likelihood of failure of vaginoscopy	Use the smallest diameter hysteroscopes. Consider using a speculum with cervical instrumentation and/or local anaesthesia and cervical dilatation if it is necessary to use hysteroscopes of diameter > 4.5 mm (no vaginal deliveries) or > 5.5 mm (vaginal deliveries) in operative procedures. Once the cervix is dilated, the speculum can be removed and a vaginoscopic approach undertaken. If vaginoscopy is not possible, offer the woman the choice of trying a speculum, local anaesthesia and dilation, or re-booking for a general anaesthetic.
Minimise distension of the uterus	Keep inflow and distension pressures as low as possible to maintain a view. Reduce inflow – e.g. if not using an automated fluid management system set to low pressures, by partial or full closure of the inflow tap, by reducing pressure or height of bag of fluid. Consider doing this routinely on entering the uterine cavity (start 'low' and build up).
Expediency	Perform a systematic inspection of the uterine cavity and genital tract in a timely fashion. The average time for a diagnostic procedure from genital tract instrumentation to removal of the hysteroscope should normally be < 3 minutes. Most operative procedures should be completed within 15 minutes and ideally within 5–10 minutes. Consider stopping if operative procedures are taking longer than 10 minutes.

5. After the procedure

5.1 Care of women

Assess and treat immediate pain control needs.

Offer recuperation in a dedicated recovery area with comfortable chairs (e.g. recliners) and privacy where necessary (e.g. curtained off areas with bed(s)/trolley(s)). Offer refreshments to the woman and anyone accompanying them. Provide access to longer stay for recovery where pain cannot be easily controlled or complications have arisen during the OPH, although this should be only rarely needed.

5.2 Communication

Explain the clinical findings and discuss further management including how histological/cytological/microbiological results will be conveyed and the likely timescales. Complete procedure (operation) note, discharge summaries/clinic letters for the woman/GP, etc.

Give post-procedural patient information, ideally both verbally and written, and include contact numbers should the woman have any problems or concerns in the next few days. In particular, women should be told to make contact if within the next 2 weeks they experience abdominal pain not controlled with simple analgesia, bleeding heavier than a period or signs of sepsis, including fever, rigors and/or malodourous vaginal discharge especially in the presence of abdominal pain.

The woman should be informed if any follow up is required and how (in person or remotely), and when this will take place.

5.3 Quality assurance

Consider data collection for quality assurance purposes, e.g. record feedback from the woman (local or BSGE Outpatient Hysteroscopy – Patient Satisfaction Survey Questionnaire, audit proformas for procedural data. Units should collect patient-reported outcome data, benchmark themselves against published norms and strive for continual improvement.

Follow the standards set out in the NICE Quality Standard *Heavy menstrual bleeding* [QS47][10] – e.g. using benchmarked, patient-reported outcome measures including pain scores.

6. Conclusion

OPH is one of the commonest diagnostic and therapeutic interventions in contemporary gynaecological practice. The evidence to support its use for diagnosis and treatment of uterine pathologies is strong. The procedure is acceptable to the majority of women, being convenient, safe and quick. However, some women will feel severe pain and some have reported extremely distressing experiences. This guidance outlines best practice and how to minimise the chances of women having a painful and poor experience. It is of key importance that clinicians are well trained, follow best practice guidance and use the best surgical and imaging technologies to minimise the number of women having a poor experience.

Women should be fully informed before the procedure, with both written and verbal high quality and accurate information, and be offered a choice of pain control options. Women preferring pain control requiring the presence of an anaesthetist (i.e. general or regional anaesthesia, or intravenous sedation) should have their hysteroscopy rescheduled. Similarly, any woman undecided about the setting and choice of pain control should not feel pressured into going ahead with an outpatient procedure and be given more time to reflect and have a further appointment made. It is particularly important that clinicians and their clinical teams work in harmony with each individual woman undergoing OPH, advocating for her and stopping the procedure immediately at her request if too painful or distressing.

OPH units and individual practitioners should regularly quality assure their practice to identify areas where improvement can be made, investigating the reasons for any deficiency. The BSGE has provided a useful tool to evaluate patient experience and benchmark against national data (see additional information and resources below).

Additional information and resources for clinicians and women can be obtained from the:

- **BSGE**
  https://www.bsge.org.uk/hysteroscopy/
- **RCOG**
  https://www.rcog.org.uk/en/patients/patient-leaflets/outpatient-hysteroscopy/
  https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg59/

7. Tools for implementation

In order to optimise the woman's experience of OPH the key areas discussed in this Good Practice Paper are summarised in the following table.

Table 1. Summary of key areas for optimising the woman's experience of outpatient hysteroscopy

Before the procedure	During the procedure	After the procedure
• Communication with the woman • Informed decision making • Information provided about 'see and treat' • Checklist (WHO/local version) • Environment • Advocacy for woman • Information provided about pain control	• Adequate resources • Advocacy for woman • Technical aspects/proficiency • Involvement of woman • Data recording • Concomitant procedures; ensure indicated, appropriate and discussed with the woman • Pain control; consider local anaesthesia and inhaled analgesia • Communication with the woman and clinical team • Clinical and technical tips for reducing or mitigating pain during the procedure	• Care of woman • Communication with the woman • Quality assurance

8. Future considerations

The joint RCOG/BSGE Green-top Guideline No. 59 *Best Practice in Outpatient Hysteroscopy*, published in 2011, is undergoing major revision including updated suggestions for research. Any recommendations arising from this evidence-based guidance should be complied with. The available evidence to date supports the safety, acceptability, accuracy and effectiveness of many outpatient hysteroscopic interventions. Moreover, the COVID-19 pandemic has highlighted the benefits of outpatient procedures, minimising the risks of aerosol generation associated with general anaesthesia, and nosocomial infection arising from hospital admission.

Those tasked with providing contemporary, high quality gynaecological services in primary and secondary care would be wise to invest properly in OPH services and other ambulatory services. This requires investment in training, equipment, infrastructure, staffing and quality assurance. Fully resourced OPH services, including the need for a proportion of women to have procedures rescheduled under other types of anaesthesia/intravenous sedation, can then deliver efficient, high quality care appreciated by women, with the aim of preventing them having a poor and unacceptable experience.

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Conflict of interests

Completed declarations of interests forms are available on request.

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