Does direct referral after an abnormal smear improve patient experience?

This research study evaluates patients’ experience of colposcopy following direct referral

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Background: Process-mapping of the patient pathway at the Birmingham Women’s Hospital revealed that, after an abnormal smear was identified, women could experience a significant delay before referral for treatment. The direct referral policy was introduced in 2007 as part of a wider pan-Birmingham project to address this.

Aim: To investigate the impact of the direct referral policy on patient experience.

Method: An integrated survey was conducted (n=200) and collected both quantitative and qualitative data. Following the introduction of a new information booklet, the same survey was repeated (n=200).

Results: The findings showed that, although there was improvement in the information provided, some women stated that no information was received.

Discussion: This highlights the fact that, while there is a need to repeat annual patient surveys to ensure the patient pathway is as robust as possible, surveys may not capture the quality of patients’ clinical experience. Suggestions are made to address this (see Implications for practice).

Conclusion: This study shows the importance of evaluating any changes in care delivery. The direct referral policy has reduced the time it takes for women to be seen in the colposcopy department following an abnormal smear.

BACKGROUND

The NHS cervical screening programme (NHSCSP) was established in 1988. It has a call-recall system, where women aged 25–64 registered with a GP are automatically called for a cervical smear every 3–5 years, depending on age.

This allows women with precancerous cervical abnormalities, known as cervical intraepithelial neoplasia (CIN), to be identified. CIN is graded from 1 to 3 and may develop into cancer if it is not treated.

CIN 1 is low grade and affects less than one-third full thickness of the cervical epithelium. CIN 2 is moderate and affects half to two-thirds full thickness of the epithelial layer and CIN 3 is high grade and affects two-thirds to full thickness of the epithelial layer.

A comprehensive programme of regional and local quality assurance with peer review visits was introduced in 2000 to monitor colposcopy services through a quarterly data collection tool known as the KC65 (Department of Health, 2000). This is used by regional quality assurance teams, health authority commissioners and directors of public health to assess the performance and workload of colposcopy services so they can be evaluated and compared against national standards. The KC65 is part of the NHS Cancer Information Strategy, which aims to improve the effectiveness and efficiency of care delivery for those with actual or suspected cancer throughout the patient journey. It also supports the National Service Framework for Cancer Services.

The cervical screening programme has led to greater detection and treatment of women with pre-invasive disease. It has also prompted the development of the nurse colposcopist role, which involves working alongside medical colleagues to address increasing workloads (McPherson et al, 2005).

Nevertheless, there were growing problems in adhering to quality assurance standards locally. These stipulate that 90% of women with invasive cancer should be seen within two weeks, those with high-grade smears within four weeks and those with low-grade ones within eight weeks. In addition, women with three consecutive inadequate smears or three consecutive smears showing borderline changes should also be routinely referred for colposcopic examination.

The delay in the patient pathway following detection of abnormalities in a smear may lead to increased anxiety for the women concerned (Martea et al, 2005; Bekkers et al, 2002).

IMPLICATIONS FOR PRACTICE

● This study demonstrates the importance of monitoring changes in healthcare delivery.

● It has also shown improvements in the time it takes for women to be seen in the colposcopy department following abnormal smears, which is significant in terms of easing patient anxieties.

● Surveys are known to provide quantitative data in response to specific factual questions to evaluate patient experience. However, while they may be a cheap and relatively easy method of achieving this, they may not capture patients’ own views and priorities.

● This could be addressed by: holding focus groups to hear first hand about the realities of care; ensuring that women’s views are incorporated into further improvements; and developing a UK-wide system of assessing colposcopy services.
The direct referral policy

In 1997 the Birmingham Women’s Hospital introduced the direct access policy, where GPs fax referral letters for women with abnormal smears directly to the hospital to speed up the referral process.

To build on this initiative, the next logical step was to undertake process-mapping of the whole colposcopy pathway. This mapping revealed that, after an abnormal smear had been identified in the cytology department, women continued to experience a significant delay before they were referred to the colposcopy department and the treatment provided.

Delays could be encountered at any stage of the patient’s care pathway. For example, a GP’s pressure of work or absence due to leave may delay a referral being made to the hospital or the request being mislaid. A further bottleneck may be within the hospital system. Booking office staff need to register referral letters on the hospital system before they are triaged to a clinic by nurse colposcopists. Finally, an appointment has to be authorised by the colposcopy department before details are posted out.

As a result, the process could take more than three weeks, making achieving the four-week standard difficult for relevant patients. It also led to urgent patients being booked into already full clinics, which caused increased stress for staff in the colposcopy department and apprehension for patients in the waiting room.

Regular working group meetings were held to plan the new process. This involved learning the working procedures of the colposcopy and cytology departments to work out how to improve patient experience.

Pan-Birmingham meetings involving colleagues in the hospital and primary care settings were held. This was essential as the Birmingham Women’s Hospital receives cytology requests from 90 surgeries across Birmingham. This consultation process also involved the South Birmingham PCT nurse practitioner, who advised GPs about the proposed introduction of direct referral.

An information leaflet explaining the direct referral policy was designed and discussed in user-representative groups before gaining quality assurance approval. Letters informing the GP concerned and patients with abnormal cytology were redesigned to advise women they would receive an invitation to attend the colposcopy department at the Birmingham Women’s Hospital. These were approved by the West Midlands Cervical Screening Quality Assurance Reference Centre and the Birmingham Women’s Hospital’s trust board.

Following introduction of the direct referral policy, if an abnormal smear requiring colposcopy referral is identified, the statement ‘this patient has been directly referred to colposcopy’ is included in letters to GPs and patients.

The cytology laboratory telephones the colposcopy department each morning from Monday to Thursday to inform them of any referrals awaiting collection. Clinic capacity and appointment availability are assessed and referrals triaged accordingly, adhering to quality assurance standards. All triaged referrals are marked with a red pen, dated and separated by referral type before being sent to the liaison officer in the booking office.

An invitation letter is then generated within 72 hours. The letter clearly states how the appointment can be changed if inconvenient and a comprehensive information leaflet is included. Contact details for the colposcopy coordinator are provided to discuss any anxieties/counselling about the procedure.

The patient’s GP is notified of the smear results and immediate colposcopy referral at the same time.

The failsafe officer in the cytology department checks that all the direct referrals have allocated clinic appointments. This streamlines the patient pathway by reducing delay, and eliminating potential blocks.

It was hoped that this would improve the quality of care, leading to positive patient experiences. This is important since it is known that abnormal smear test results can create severe psychological distress in women (Freeman-Wang et al, 2003; Rogstad, 2003).

Clinical studies have shown that, in 99.7% of cases, cervical cancer is caused by the human papilloma virus (HPV) (Muñoz, 2000). This infection is acquired through sexual activity. There are many different strains of HPV, but the ones most associated with the development of cancer are subtypes 16, 18, 31, 33 and 45. For other predisposing risk factors associated with this disease, see Jefferies (2008). The presenting symptoms of cervical cancer are shown in Box 1.

AIM

Three months after the introduction of the direct referral policy, a survey was undertaken. This had two objectives. The first was to assess patients’ satisfaction with the timeliness of their colposcopy appointment. The second was to assess their satisfaction with the information provided. The thinking behind this was as follows:

- Were patients receiving the written information in time for their appointment?
- Did it answer their questions?
- If not, was there an opportunity for them to have their questions answered before their visit?
- Was there time for the GP to inform the colposcopy department if the patient had a disability or another concern?
- Is there a sense that women were being referred too quickly?
- Is the new pathway in good working order?

A survey was chosen as it is a simple way of collating this information. There were 12 questions and space for comments (see Appendix 1 at nursingtimes.net).

METHOD

The surveys were distributed to patients when they attended their first clinic appointment and they completed them.
**REFERENCES**


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**TABLE 1. PERCENTAGE OF WOMEN SEEN WITHIN TARGET TIMES**

<table>
<thead>
<tr>
<th></th>
<th>QA standards</th>
<th>Oct–Dec 07, after direct referral</th>
<th>Jan–Mar 05, before direct referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within four weeks</td>
<td>90%</td>
<td>98.5%</td>
<td>68%</td>
</tr>
<tr>
<td>Within eight weeks</td>
<td>90%</td>
<td>95%</td>
<td>88%</td>
</tr>
</tbody>
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before they were seen. The first survey was undertaken between May and June 2007 and involved 200 women. It was discontinued once that number had been reached.

Conducting the survey while patients were awaiting their appointment ensured that the data was gathered within a short space of time with a 100% response rate. This was preferable to and less expensive than a postal questionnaire. However, there may have been an element of bias as the women may have thought they had to provide favourable answers as they were answering the questions on hospital premises.

The survey was repeated approximately 12 months later. This time frame was chosen as, in the interim, a new regional patient-information booklet had been produced. The process of developing the booklet involved undertaking pilot studies, involving patient focus groups and gaining approval from the regional quality assurance representative.

It was approved by the Plain English Campaign, which awarded it a crystal mark logo. This symbol is widely recognised as a guarantee that a document has been written and designed as clearly as possible. The leaflet was also ratified by all trusts in the West Midlands.

By conducting two surveys, we hoped to ascertain if the new booklet had improved information provision.

**RESULTS**

The first survey found that 98% of women received the information and read it. It answered the concerns of 92% of the total, while the other 8% sought further information from, for example their GP or a relative. Five per cent of the total telephoned the colposcopy department for specific advice. One per cent (two women) were unable to read the booklet as they found the language too difficult, and one woman did not receive any information with the appointment letter.

The second survey revealed that 97% received the information and 94% read it. The women who had not read the information remarked they had not bothered as they had attended the clinic on a previous occasion.

All those who read the booklet found the information easy to understand and it answered the concerns of 97%. Despite the improved information booklet, 6% of the total sought further information from a friend, GP or the colposcopy coordinator. This may indicate that some women prefer to discuss their colposcopy visit with a person, one to one, rather than relying on written information alone.

The vast majority of women found that attendance at the colposcopy department was a positive experience. Comments included: ‘Staff fully explained everything; put me at ease’ and ‘I was informed in a reassuring and sensitive way and given full information… the follow-up appointment was of an equally high standard.’

Negative comments received related to the wait for the appointment. Some women would have preferred to be seen sooner.

Comments included:
- ‘The wait has been awful, playing on my mind’;
- ‘[Appointment] sooner would have been better’;
- ‘I would have liked to have been seen more quickly to alleviate anxiety.’

An audit showed that, since the direct referral policy was introduced, 98.5% of those who should be seen within four weeks are seen in that time, compared with 68% previously. It also found that 95% of those who should be seen within eight weeks are seen in that time, compared with 88% previously. The quality assurance standards for both groups are 90% and are shown in Table 1.

The policy has also led to better working relationships between primary care and the colposcopy and cytology departments, resulting in greater job satisfaction.

As one GP noted: ‘Cytopathology service has been improved – the most impressive [feature] is sending the direct referral to...
[inform the] patient of [their] abnormal result.’

The next challenge to this pathway is at the start of the patient’s journey. By the year 2010, the NHS hopes to instigate a 14-day turnaround from the time the sample is taken to the time it is reported.

DISCUSSION

The surveys were used to monitor the impact on patient care following a change in working practice. They were a relatively quick and easy method of assessing whether the direct referral pathway had had an impact on the timeliness of the colposcopy appointment and information provision.

It is thought that continual monitoring using patient satisfaction surveys provides the most accurate results (Friedberg, 2007). However, we would question whether such surveys provide accurate feedback on patients’ experiences. While the surveys at the Birmingham Women’s Hospital audited the timeliness of patients’ appointments, they did not assess women’s views on: the interpersonal skills of the doctor or nurse colposcopist who treated them; whether they were given time to ask questions and be listened to; or the manner in which their privacy was respected and dignity maintained. Therefore, the quality of the women’s experience – which would indicate the clinician’s level of expertise, knowledge and judgement – was not assessed.

This may be achieved in several ways. A multi-method research study is being undertaken by a PhD student at a university in the Midlands, which seeks to investigate the experience women have of being referred for, and undergoing, colposcopy.

In-depth interviews have been conducted with women to discover which aspects of the appointment were important in their experience. Six factors were identified, and these were used to construct a preference-based questionnaire. This will rank the relative importance of these factors in terms of women’s preference by asking them to identify the ‘best thing’ and ‘worst thing’ from various hypothetical appointment scenarios. The outcome will report women’s preferences for aspects of their colposcopy appointment.

This study will be important since quality care must be based on an understanding of patients’ needs, desires and expectations. However, while the findings will provide insights to improve future care and increase healthcare professionals’ knowledge base, these suggestions must only be tentative since a relatively small number of women participated.

Although there is a biennial regional satisfaction survey in the West Midlands, perhaps there is a need for all colposcopy centres to conduct an annual review of their service using a national framework. This could consider:

- Women’s views on practitioners’ communication skills. Did patients have a clear understanding of their condition and the rationale for any treatment explained? Did they receive any ‘bad news’ in an appropriate manner, with psychological and written informational support?
- Is there an association between women’s trust in their clinician and satisfaction with the care they received?
- Does regular follow-up with the same doctor or nurse colposcopist have an impact on women’s views of services?

A national survey would ensure there was a standard questionnaire collecting the same information, ensuring validity and reliability. By meeting standards of conceptual or methodological rigour, they could also facilitate quality improvement efforts (Cleary and Edgman-Levitan, 1997). Local centres would then be able to calibrate their service with others against a national standard and use the results to improve patient satisfaction with all healthcare professionals involved in care provision.

This may be similar to the Consumer Assessment of Health Plans (CAHPS) project, which adopted a similar approach for ambulatory care in the US. It provided qualitatively better data than many earlier surveys and improved the quality of healthcare (Cleary and Edgman-Levitan, 1997).

CONCLUSION

This study demonstrates the importance of evaluating any changes in care delivery. It has shown that the direct referral policy has led to an improvement in the time it takes for women to be seen in the colposcopy department following the identification of an abnormal sample. This is clearly important as women’s responses to the questionnaire indicate that a delay in referral may lead to a heightened sense of anxiety.

While all healthcare professionals need continually to monitor and develop services to ensure that care is delivered in the best way, it is equally important that the most appropriate research method is used to gain an insight into patients’ experiences.

Cervical smears are now commonly referred to as cervical samples to reflect a change in practice. Rather than smearing the sample onto a slide (as with the Pap smear), liquid-based cytology is now used for preparing samples. In LBC, the spatula’s head, where the cells are lodged, is broken off into a glass vial containing preservative fluid, or rinsed directly into the fluid. The change was completed in October 2008.

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