

1. Project information

Fellow's name	Dr Penelope Sheehan
Title of project	Postnatal Debriefing Project
Fellow's study area	Access A study of postnatal review services in tertiary maternity centres
Fellow's organisation	The Royal Women's Hospital
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2. Project summary

Top three outcomes

- Opportunity to closely observe three different service models for a postnatal discussion program attached to a large tertiary maternity hospital: midwifery-led, community based, midwifery-led, hospital based, or obstetrician led.
- Access to formal evaluations of the services where these were available.
- Establish contact with academics and leaders of research in the area of birth trauma.

Main activities undertaken

- Meetings with clinicians responsible for various postnatal debriefing services at maternity hospitals in the United Kingdom.
- Meetings with managers responsible for these services.
- Observation of clinical debriefing sessions with patients.
- Meetings with quality and safety officers where links to these services existed.
- Discussion of potential research in the area with academic staff and consumer group.
- Discussion of the need in the community and scope of the problem with consumer group.

Major learnings

- Services led by midwives appeared to have greater benefit in terms of feedback to primary carers. Clinical leadership by those involved in the various programs in their usual areas of work was extremely effective in raising awareness of birth trauma among staff and also in promoting the service.
- Hospital-based service was most cost-effective while still retaining some flexibility for patients.
- These services benefit from a formal structure and evaluation.
- There would be further benefits from formal reporting to hospital quality and safety programs and complaints services.
- A patient support group may also be effective.

Lessons for the Victorian healthcare system

- A postnatal review service for a Victorian tertiary hospital should have a formal structure with a steering group, formal evaluation program, formal

reporting to quality and safety, a stated budget and clear management responsibility.

- The most effective and practical design is probably hospital based, midwifery-led but multidisciplinary in nature involving an obstetrician and a clinical psychologist.
- Such a service is an ideal setting for further research into the area.

3. Description of the study itinerary

The Birth Afterthoughts Program at the John Radcliffe Hospital, Oxford, UK

18 June 2007

- The John Radcliffe Hospital is Oxfordshire's main accident and emergency site. It also provides acute medical and surgical services, trauma, intensive care, cardiac services, women's services and the Children's Hospital. The Women's Centre at the John Radcliffe delivers around 5500 babies each year, as well as being a regional referral centre caring for women with complex obstetrics and neonatal cases. The maternity services are divided into high risk (also known as the 'Silver Star Service') and low risk women whose care is primarily undertaken by midwives.
- I met with Libby Searle, Co-ordinator of the Birth Afterthoughts Program at the John Radcliffe hospital.

Activities undertaken during the visit included:

- Meeting with Libby Searle to discuss the structure of the Birth Afterthoughts Program.
- Observation of counselling appointments with Libby Searle.
- Meeting with Dr Pauline Hurley, Co-ordinator of Quality and Safety for Maternity Services.

The Birth Afterthoughts Program at the John Radcliffe Hospital was first established in 1998. It was originally funded for two years. It has no direct funding at present; the midwives are paid by their own cost centres for the work they do for Birth Afterthoughts.

The service is run by Libby Searle, a senior midwife, who is paid four hours per week for her role as Birth Afterthoughts Co-ordinator. The Birth Afterthoughts Program clerical support is provided by one of the secretaries for the midwifery managers. The clerical support provided is effectively in the form of a telephone answering service for the Birth Afterthoughts contact number. Libby has a background in general nursing, midwifery; she also works as a health visitor (similar to Victorian maternal child health nurses) and has taken a diploma in counselling in the past. At present, she runs the service with eight midwives. Periodically, she puts out a request for volunteers for the service from the existing hospital staff.

Midwives for the service do not receive any formal training. They go out on observation visits with a current member of the programme (up to two visits), and then do observed visits (again, up to two) then they practice independently.

Currently, women are given a bookmark promoting the service, which is included in the information pack the women receive at the start of the pregnancy. A 2006 audit revealed that most women contact the service following information given to them by other health professionals including general practitioners (GPs) or midwives or by 'word-of-mouth' from friends who had previously used the service. In view of this finding, the laminated bookmarks were considered to be costly and not particularly effective. Other ways to promote the service are being sought, particularly focussing on health care providers.

The service receives on average ten referrals a month, about 120 per year. When the service receives a referral, they call for the woman's history from the health information system. The record is sent to an obstetrician with the note that the woman has made a request to see Birth Afterthoughts. The obstetrician reviews the record and makes any comments they would like. This also gives them the opportunity to see the woman if they would like to, although according to Libby's report, most of them simply give permission for the midwives to go ahead. The midwives then make the visit, currently to the woman at her home. Visits usually take about an hour although this is at the midwife's discretion. Libby directs midwives to try to keep to the subject of the birth and not get involved in other problems and issues in the woman's life. Following the visit, the midwife writes up a detailed report (see the included report example). A sticker is placed on the front of the woman's medical record and a transcript of the report is included in the back of the medical record, otherwise Birth Afterthoughts reports remain separate. A separate form is available for feedback to consultants following the visit.

The service underwent an audit in 2006, based on 2005 activity.

- Number of referrals 138.
- Average length of time per midwife visit, including travel and administration, three hours plus approximately one-hour office time.
- The most common reason for women attending the service was complicated NVD (37 per cent). Other common reasons included emergency LUSCS (27 per cent) and instrumental deliveries (31 per cent).
- Ten per cent of women wanted to make a written complaint at the time of the visit. (There is no way of identifying those who follow through by actually submitting a complaint.)
- Libby is not aware of anyone who has filed a formal complaint with the hospital after a Birth Afterthoughts visit. She is of the opinion that they probably prevent complaints but she has no evidence to prove this.

I also spoke to Dr Pauline Hurley, who is responsible for quality and safety related to delivery suite. She is strongly supportive of the Birth Afterthoughts

Program from its risk management point of view however she feels that her support is hampered by the lack of evidence of its effectiveness. One of the difficulties in gaining this evidence is that once the patient has entered into a formal complaints process there can be no further communication with them from the hospital for medico-legal reasons. In addition there is no communication from the complaints department about details of the different complaints and whether the complainants had attended any services such as Birth Afterthoughts. This is very frustrating for her. There is no formal link between Birth Afterthoughts and quality and safety within the hospital. If a woman seen by the service has a specific complaint, Libby encourages them to write a letter to the hospital, not necessarily a letter of complaint but merely feedback. Libby does not fill out an incident report from the Birth Afterthoughts interview, but may give a report to a relevant manager, who then may make an incident report if necessary.

Main strengths of the program:

- The midwifery-led service is consistent with the structure of maternity care in the UK.
- Midwifery involvement in the program results in good feedback to primary carers. The midwives involved in the service become clinical leaders almost incidentally as the result of hearing about women's experiences through counselling episodes.
- The program is extremely flexible, frequently visiting women at their home and allowing women to choose the time of the visit, including the possibility of evening visits.
- The program keeps clear records of its activity.

Weaknesses of the program:

- The lack of dedicated funding results in a lack of forward planning for the service due to the uncertainty of its future. As a result, improvements to the service, audit and succession planning are performed in an ad hoc fashion.
- The program has no clear place in the management structure of maternity services. The Manager, Libby Searle reports to three different maternity managers. This creates barriers to service improvement and difficulties in day-to-day service activity.
- There are no formal links to quality and safety mechanisms.
- There are no formal links to complaint services.
- The program is currently community-based however this has proved to be too costly even in the UK, which has a stronger system of community support than that currently existing in Australia.

The Birth Afterthoughts Program at the Rosie Maternity Hospital at Addenbrookes, Cambridge, UK

26 June 2007

- The Rosie Maternity Hospital is part of the Addenbrookes Hospital, a general tertiary hospital serving the Cambridgeshire area. The Rosie has approximately 6000 deliveries per year and offers both midwifery and consultant-led care.
- I met with Pat Ingham, Co-ordinator of the Birth Afterthoughts Program at the Rosie.

Activities undertaken during the visit included:

- Meeting with Pat Ingham to discuss the structure of the Birth Afterthoughts Program.
- Attending a general meeting of the Birth Afterthoughts 'team'
- Observation of counselling appointments with Pat Ingham and other team members.
- Meeting with Emma Hardwick, Manager responsible for the Birth Afterthoughts Program.

The service at the Rosie Maternity was set up in 1998 by a group of six midwives. The aim was to provide a service for women that enabled them to come to the hospital for an opportunity to discuss their childbirth experience, in a safe environment. It was initially considered that if more than one visit was necessary then alternative services should be offered, for example, a consultant appointment in the outpatients department, or with a counsellor if there were issues that could not be resolved. The obstetric consultants were approached and agreed to this service being offered, and a counsellor was asked to join this group. The steering group consisted of the counsellor, the labour ward manager in the role of manager and supervisor of midwives, and a GP, who was invited for support should community issues be identified. One of the obstetric consultants was particularly supportive and approachable, and offered 'expert' advice if necessary. The service was not envisaged as a counselling service but as an opportunity for women to 'defuse' and discuss their labour and delivery. This steering group provided the service with formal 'terms of reference' although it has not met for some time.

Pat Ingham, the current Program Co-ordinator, is a British Association for Counselling and Psychotherapy accredited counsellor. Her previous experience included setting up a bereavement counselling program at a smaller community hospital. Pat took over the role of program co-ordinator in 2002, running the program with the assistance of ten other midwives who also work as both community midwives and as part of the midwifery-led care

program. The program receives an average of ten referrals per month. Pat is employed full-time, and undertakes about two-thirds of the counselling.

Midwives recruited to the service observe two counselling sessions and then commence independent practice. There is no formal training or accreditation. Women are provided with an evaluation form to complete after the debriefing session; from June 2003, this has been accompanied by a stamped addressed envelope for return, which has increased their return rate. The program co-ordinator follows up any unsatisfactory evaluations with both woman and midwife.

An information leaflet regarding the program is given to each woman on her discharge from hospital. In a 2005 audit, the most common source of information was the community midwife followed by the leaflet given out to women on discharge from hospital. The information leaflets are thus thought to be effective in promoting the service.

Women access the service via a telephone answering machine. There is no secretarial support. The call is retrieved by the bereavement midwife counsellor, who then passes the woman's contact details to the midwife who will undertake the interview, if she is not able to do this herself. The midwife then telephones the woman back and arranges a date for the meeting as soon as possible. Consultant agreement used to be obtained for each interview however this practice has been discontinued. Consultants are not specifically notified of a woman's request for review.

Each midwife undertaking the interview also records an evaluation of the session, the key themes identified by women and the actions taken. The report of the Birth Afterthoughts session is kept separate from the patient's file. There is no record of the request for counselling or the issues discussed in the patient's file. Women are seen for 90 minute counselling sessions, which take place at the hospital. As Pat works full-time there is some flexibility regarding appointment timing.

The service has no formal link to risk management structures within the hospital. Pat notes that in the past when she has identified potential sentinel events, incident reports have been already been submitted by clinical staff at the time of the incident. Feedback from the services relies on Pat, as Co-ordinator, approaching managers or consultants personally as appropriate. There is no information on complaints made by women.

The service underwent a formal evaluation in 2005, based on a 2004 audit.

Major findings included:

- Over 70 per cent of referrals were seen within one month of the initial contact. The majority of delays were due to the women themselves. Almost 10 per cent of referrals involved some difficulty obtaining the notes.

- The majority of referrals were from women between one month and one year after the birth; these were evenly spread over the months analysed.
- Emergency caesarean section was the most common type of birth that women had experienced when referred to the service. Caesarean section and instrumental delivery were disproportionately represented as the most common birth outcomes.
- The effectiveness of the debriefing sessions was evaluated by the midwives on their evaluation forms and by the women in response to the question 'was the interview helpful?' The comments were overwhelmingly positive.

Major strengths of the program:

- The formal structure, including steering group, terms of reference, regular group meetings et cetera, sets out a framework for good clinical governance.
- Supportive management.
- Some flexibility with appointments as the co-ordinator is available throughout the week.
- Ninety minute counselling sessions involved detailed record review.
- Confidentiality maintained by separate records.
- Midwifery involvement in the program results in raised awareness of issues among midwifery teams.

Major weaknesses of the program:

- Counselling sessions observed are very directed toward close examination of the birth record. Current health problems are not well addressed.
- There are no formal links to Quality and Safety mechanisms.
- There are no formal links to complaint services.
- The separate record maintained by Birth Afterthoughts results in improved confidentiality but issues raised during counselling sessions may be important knowledge for future care providers.

Postnatal Review Clinic at Royal Berkshire Hospital, Reading, UK

1 July 2007

- The Royal Berkshire Hospital provides acute hospital services to the residents of West Berkshire. Currently the hospital has over 5500 births each year. Models of maternity care available include midwifery-led care for low-risk patients and obstetrician care for those deemed high-risk.
- I met with Dr Helen Allott, Staff Obstetrician, providing the service.

Activities undertaken during the visit included:

- Meeting with Helen Allott to discuss the role of the Postnatal Review Clinic.
- Observation of counselling appointments with Helen Allott.

The Postnatal Review Clinic at the Royal Berkshire was set up by Dr Allott soon after she finished her training, and in response to a need that she perceived with the maternity services offered by the hospital. As opposed to the other services, this model runs strictly along the lines of an outpatient clinic, with three, one-hour appointments every Monday morning.

The clinic receives approximately 120 referrals each year. There has never been any official promotion campaign. Knowledge of the service is by 'word-of-mouth' only. Most referrals are from other practitioners with a very small number of self-referrals.

At the conclusion of the appointment, Dr Allott dictates a letter to the patient summarising the issues discussed during the visit. A copy of this letter is filed in the patient's history as the record of the visit.

If there appear to be unresolved issues, Dr Allott occasionally offers the woman the opportunity to return for a second review. A few women are referred on to other services, where appropriate, such as clinical psychology or gynaecology.

The clinic has no formal links with quality and safety. If issues arise regarding quality of care during review of a case, Dr Allott might submit an incident report or have an informal discussion with appropriate managers. Dr Allott was of the opinion that she would be informed about any subsequent complaints made by patients. In general, she thought most patients attending the service did not make formal complaints although there was no evidence around this.

Dr Allott is the sole obstetrician involved with the service. A midwife does occasional clinic sessions, in particular covering for Dr Allott's leave. Occasionally an interested trainee may attend the clinic for a number of sessions but never on a regular basis.

The service underwent a formal audit after the first hundred patients seen in the clinic but has had no formal review since then.

Major strengths of the program:

- The counselling received by the patients in this clinic was somewhat different to that of the other programs. Although each counselling appointment contained a detailed record review similar to that offered by the John Radcliffe program, there was considerably more emphasis on plans for future pregnancies and possible current health problems. There is some benefit in this for patients, as in the other programs they required a further visit with an obstetrician to discuss detailed plans involving clinical decisions or for review of possible current health problems.
- Advice given to patients is very consistent in view of the 'sole practitioner'. Dr Allott assured me that care plans made at the clinic were followed and respected by other practitioners within the hospital.

Major weaknesses of the program:

- No formal structure.
- Lack of involvement of other practitioner groups reduces the impact of the clinic on local practice and raises barriers to feedback.
- Paucity of formal evaluations.
- There are no formal links to quality and safety mechanisms.
- There are no formal links to complaint services.
- In terms of cost per hour, a consultant obstetrician is obviously more expensive than a midwife or counsellor. The overall cost of this service is probably equivalent to others seen because of the lack of infrastructure around it. The disadvantages of this approach are the lack of widespread promotion of the service and lack of formal audit activity, which a more dedicated staff member would be able to facilitate.

Birth Trauma Association, UK

1 July 2007

- Meeting with Maureen Treadwell, co-founder of the Birth Trauma Association to discuss the support and activities of the association.

The Birth Trauma Association (BTA) was established in 2004 to support women suffering from 'birth trauma' as a result of their childbirth experience. The BTA uses this term to refer to both post-natal post-traumatic stress disorder and an acute stress reaction to birth.

The BTA is the only organisation in the UK dealing specifically with this issue. It is a non-government organisation supported by private donations and run by women who donate their time. The organisation has three main aims:

1. raising awareness of birth trauma
2. working to prevent birth trauma
3. supporting families in need.

The BTA is run by the Executive Committee, consisting of a chair and five other committee members including the two co-founders. There are two trustees and a four-member board of experts who provide professional advice and information on recent developments.

The BTA provides direct help with internet information on its website www.birthtraumaassociation.org.uk, e-mail contact, internet message board chat and advice, leaflets and publications and direct telephone or face to face support from its volunteer supporters. The website currently receives more than 10,000 new hits each month in supported over 1000 women in its first year of operation. The BTA issues newsletters and has its own publications and leaflets available online for women seeking information about this subject.

The BTA is also working with researchers to identify possible causes of these types of mental health disorders as well as the best forms of treatment. Maureen is currently working with the Intrapartum Care Guideline Development Group of the National Institute for Clinical Excellence. This new guideline is due to be issued in September 2007. The BTA is also in the process of developing a proposal for collaborative research with the National Perinatal Epidemiology Unit based at the Oxford University Department of Public Health and Primary Care. This proposal aims to obtain government funding specifically targeted for user group research agendas. The BTA was instrumental in the formation of the UK Birth Research Network. This network includes researchers from all over the UK who are interested in the effects of childbirth on women and their families. The BTA supports online research projects with links on their webpage. Currently their homepage

contains a link to an online research survey conducted by a postgraduate researcher based at the University of Kent.

The BTA runs seminars and held the first multi-disciplinary conference in the UK on this issue in June 2005. Current work has focussed on establishing the first Birth Trauma Awareness Day in the UK, which was planned for 18 August 2007.

Volunteers from the BTA are sometimes asked to take part in training programs for health workers involved in childbirth. Maureen regularly conducts a lecture for the midwifery-training program based in East Sussex.

The BTA is a very active group in developing research agendas, raising awareness of the issue and supporting women. Judging from the response, there must be considerable need for this type of support organisation within the community. A postnatal review service would benefit from the establishment of an associated support group.

University of Sussex, UK

27 June 2007

- Meeting with Dr Susan Ayers, Senior Lecturer, University of Sussex and Consultant Clinical Psychologist.

Susan is a Senior Lecturer in Health Psychology at the University of Sussex. Her main interest is the development of post-traumatic stress disorder after health events, particularly childbirth. She has undertaken qualitative and quantitative studies of traumatic birth and published widely on the topic.

We discussed the (unpublished) results of her PhD student on the topic. Her student's thesis demonstrated that women appreciated the opportunity to discuss their birth experience although for those suffering from post traumatic stress disorder (PTSD), although this sort of counselling could be useful in helping women to understand the events surrounding the birth of their baby, it was unlikely to resolve established symptoms of PTSD. Cognitive behavioural therapy is a more structured therapy where the events of the birth experience are reviewed along with perceptions and thought processes and relaxation techniques are used to try to assist in reviewing particularly difficult or traumatic aspects of the birth.

We discussed leading theories of the development of PTSD and also current published research in the area, particularly the limitations of the published research. I described my plans for evaluation of the new service to be established at the Royal Women's Hospital (RWH), and Susan made some helpful methodological suggestions.

We concluded:

- More research is required in the area of postnatal PTSD.
- The establishment of a new postnatal review service is a good opportunity to conduct research in this area as well as conduct a formal evaluation of the effectiveness of such a service.

4. Improving the Victorian healthcare system

The next steps at RWH:

- A working group has already been established at the RWH to assist with the inception of a postnatal review service. Following the findings of my fellowship, a format for the service will be determined and a steering group formed.
- A launch of the new service to inform health providers of its existence and raise general awareness of the issue.
- The establishment of a support group if an appropriate community leader can be found.
- A research project into current satisfaction with birth experience and prevalence of PTSD and postnatal depression has already commenced. It is envisaged that this might form the first part of a service evaluation process, to be compared to a repeated measurement performed 2 years after the establishment of a postnatal review service.

5. Sharing and promoting the project

It is anticipated that we will present our experiences in establishing and evaluating a postnatal review service as well as current related research into negative birth experiences at appropriate conferences such as:

- Women's Mental Health Conference (in Melbourne early 2008)
- RANZCOG ASM

Our findings will also be submitted for publication to appropriate peer-reviewed journals such as ANZCOG, O&G magazine.