Specialist Obstetric and Gynaecology Service

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History

* A service to maternity has been present at Hillingdon Hospital since late 1990's
* Innovative Obstetrician and Gynaecologist
* Clinical Psychology Service since 2005
* Before PMHT would liaise with CMHT's and Psych Liaison.

* 1 Clinical Psychologist 2 days (.4 WTE) to maternity

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Location

* Located physically in the Hospital but not maternity dept
* Part of Maternity MDT
* Part of the Clinical Health Service

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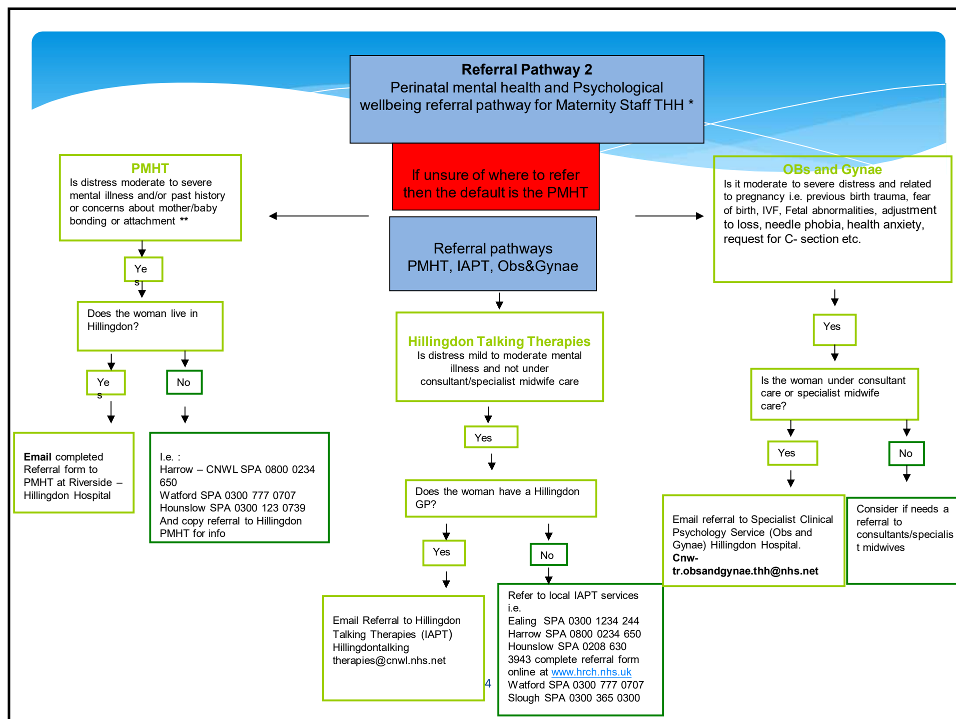
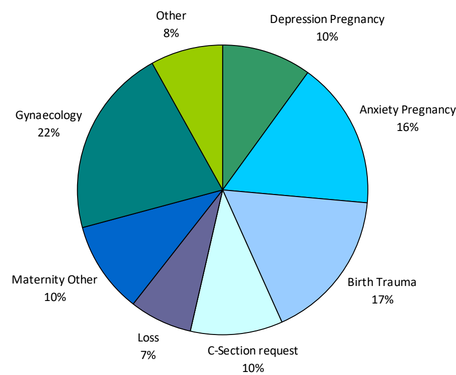


Difficulties that complicate pregnancy

Clinical Psychology service



What is provided

- Antenatal and Postnatal work with individuals and/or partners.
  - Principal – Continuity of care that flexibly meets client's needs.
- Run groups with midwives ie Anxiety
- Provide Psychology Care-plans for labour, birth, postnatal care in maternity.
- Consultation to maternity staff
- Service development
- Liaise with Obstetricians, Anesthetist, 'Topaz' team.
- Joint work with IAPT and PMHT
- Supervision to IAPT
- Training in Maternity

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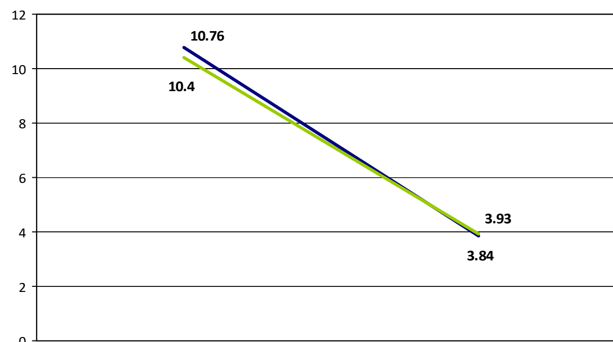
Effectiveness



The significant reduction in scores represents a clinically significant change with patient scores indicating moderate depression (as measured on the PHQ) and moderate anxiety (as measured on the GAD) when entering the service. At the time of leaving the service mean patient scores no longer met the clinical threshold for depression and anxiety as measured by these questionnaires.

Psychology Care-plan

Care pathway for women who have had a previous traumatic birth or extreme fear of childbirth: As part of the MDT (Midwives, Consultants and Anaesthetists) the Clinical Psychologist provides psychological care-plans for labour, birth and postnatal care as part of psychological interventions during pregnancy. Towards the end of pregnancy a care-plan is developed by the clinical psychologist in conjunction with the woman and MDT and circulated to senior staff involved in both her antenatal and postnatal care. The care-plan consists of: 1, a brief summary of relevant background and particular psychological difficulties which may impact on labour and birth and 2, psychologically informed recommendations in the form of bullet points for staff to provide individualised care and support to the woman in their care. The development and circulation of the care-plan improves trust in the system and in health care professionals, enables the woman to feel heard, respected and for her needs to be met and enables staff to provide psychologically informed care improving job satisfaction. It reduces incidence of PTSD with ongoing negative impact on the woman's mental health, child and family. Common themes have have also led to service developments. It ensures 'parity of esteem' and meets NHS England's standards of care.

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Date: 11th July 20
Clinical Psychology Report for B
Patient Number
EDD 15th August 20
Planned C-Section 6th August 20

Background

B experienced a traumatic birth in 2014 at a hospital in East London (under special measures) which left her with gynaecological problems subsequent to a 3c tear. B went into spontaneous labour at 37/40 following her water's breaking. Dilation did not progress and she was then induced and had an epidural for pain relief. She developed an infection during labour and felt feverish and described feeling "in and out of it". She recalled being "shouted at" by staff because she was not able to push her baby out and that the alarm was sounded. B had an episiotomy. Initially a ventose was tried but came off and then her daughter was born using forceps. B described feeling that her daughter was being "ripped out" of her. An artery was cut during the episiotomy and B began to lose a lot of blood and to feel weaker and weaker. She was told she was tired. Her husband, C, had noticed the change in her and because of his medical background became increasingly concerned and checked under the sheets, saw "blood everywhere" and raised the alarm with staff. B was rushed into theatre.

She was terrified that she would not wake again and C was terrified that she was going to die. This traumatic experience left C with PTSD and B and C delaying having a second child because of their intense fear. B and C have been under the care of Miss and Clinical Psychology and more recently because of gestational diabetes, Miss Dutta.

In order to promote B's and C's mental health and psychological wellbeing it is important that the following is taken into consideration when making her care-plan.

Triage/Labour Ward

If B goes into spontaneous labour before the planned C-section date she will come into Triage immediately. If medically possible she would like to continue with a C-section as agreed with Miss Dutta.

B and C will benefit from experienced members to staff involved in their care. B would prefer not to have a student midwife involved in her care.

B and C have attended a hypno-birthing course and benefit from the techniques learnt to cope with anxiety. They will benefit from being prompted to use these if needed.

B and C are understandably extremely anxious and are likely to be hypervigilant for any signs that there are problems. Any ambiguous signs or reassurances such as 'whispering' may result in B and C interpreting the actions as an indication that there is a problem which may lead to increased feelings of anxiety. They will both benefit from detailed (contemporaneous) information about B's care.

B and C will benefit from specific information when reassured. Reassurance such as "everything is fine" will not be helpful and they may feel 'fobbed off' as they felt during their last traumatic birth.

B would like to establish breast feeding and to have skin to skin as soon as possible with her baby. Because of gestational diabetes she has harvested colostrum.

Postnatal Ward.

B and C will benefit from their own room following the birth of their baby.

Dr Sarah Finnis
Principal Clinical Psychologist
Obstetrics and Gynaecology

cc
Matron
Antenatal Clinic
Labour Ward
Alexandra Ward
Katherine Ward
Anaesthetist
Consultant
Breast feeding Co-ordinator

Fear of Childbirth (Tokaphobia)

- https://www.healthylondon.org/wp-content/uploads/2018/01/Tokophobia-
- best-practice-toolkit-Jan-2018.pdf

Healthy London Partnership

NHS London Clinical Networks

Pan-London Perinatal Mental Health Networks

Fear of Childbirth (Tokophobia) and Traumatic Experience of Childbirth: Best Practice Toolkit

January 2018

Effective date: 31/01/2018
Due for review: 1/04/2019

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Work with PMHT

Case 1:-

36 year old. IVF pregnancy. Discontinued Fluoxetine when found pregnant. Midwife referral to the PMHT because of increase in anxiety. Background:- Married. Husband on the AS. Previous history of anxiety at school & Uni. Needle phobia. Partial right nephrectomy. Removal of fallopian tubes.

Anxiety about something going wrong with her pregnancy. Private scans. Doppler, fear of childbirth.

Referred to Obs and Gynae service.
Significant health anxiety and relationship stress and fear of childbirth.

Worked with Topaz team, psychology care plan, attended C-section.

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Work with PMHT

Case 2
31 year old married woman. History of severe OCD. Prescribed Sertraline. Fear of losing baby because of previous miscarriage a yr previously.

Referred to the Obs and Gynae service to work with fear of losing baby.

Continued with PMHT because not taking medication consistently because of fear of harm to baby

Before first assessment gave birth prematurely at 28 weeks. Baby in neonatal care.

Fearful of returning home with baby.

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