birth conversations toolkit

Royal College of Midwives

Section 1: The value of conversation: Addressing birth trauma

Executive summary

The central role of midwives is to support women through pregnancy, labour, birth and the postnatal period. This includes ensuring that women are able to make informed choices about their care and advocating for those choices on behalf of women. However, the well-documented pressures on maternity services, and the staff that work within them, often mean that support and advocacy is not at the level the midwifery community – and women and families – want and need.

The impact of this was highlighted by the 2024 report of the All-Party Parliamentary Group (APPG) inquiry on birth trauma[1] which found alarmingly high numbers of women who experience traumatic birth. During pregnancy and up to one year after birth, one in five women will experience mental health issues with higher rates seen among certain groups facing disadvantage[2].

Universal investment in postnatal care

Women who have had a traumatic or difficult birth may benefit from reflecting on their experiences with a midwife to explore their feelings. While the APPG report, and subsequent media coverage, suggests there is a strong need for this, provision of this service is not universal. Nor is there adequate investment in this vital part of postnatal care.

Consistent care infrastructure

There is an urgent need to reduce unnecessary variation in the quality and experience of UK maternity care and to ensure consistent, trauma-informed support. Having a birth conversation - a structured, compassionate discussion to help women understand what happened during labour and birth, ask questions and consider future care - could have a significant, positive impact on the experiences of women. It is not intended to replace psychological therapy or a clinical investigation, nor is it a substitute for the NHS complaints process, should women and families choose to take this route.

The delivery of high-quality and sustainable services is dependent on the infrastructure and investment being in place to support midwives to undertake birth conversations with women. This includes ongoing training for midwives, both pre- and post-registration, and sufficient time for midwives to provide this support to women and families.

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Recommendations for consistent birth conversations

1. **Service planning must be coproduced with women and maternity staff.**
2. **Specific funding allocation must allow for physical and workforce requirements.**
3. **Training for midwives, both pre- and post-registration, must be comprehensive and trauma-informed.**
4. **Midwives should be given regular opportunities for supervision and aftercare.**
5. **Services should be designed to support access for all women, especially underserved and disadvantaged groups.**
6. **Formal escalation pathways must established and clearly communicated to staff.**
7. **The delivery of services should be supported by multidisciplinary teams.**

Service planning: Coproduction with women

Specialist birth conversation services may not be the norm in every country or region and the service provided to women across the UK varies. Where possible, Trusts and Health Boards should consider introducing dedicated birth conversation services. A birth conversation service should be appropriately planned and commissioned to facilitate high-quality delivery. These services should be coproduced with women, or service user representatives, at each stage of the process[6]. Incorporating the lived experience of women and service users offers a collaborative way to design, deliver and evaluate care that is person-centred and drives continuous improvement and enhances outcomes for women and their families. Evaluation of the service should include feedback from the midwives undertaking birth conversations.

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Funding

Providers of birth conversation services should ensure that adequate funding is allocated to run an effective service. Consideration needs to be given to staff requirements including administrative time and midwifery time. Workforce capacity planning should:

- define the time elements per contact
- estimate local demand as a proportion of births
- translate expected activity into required midwifery and administrative capacity (including non-contact time for example, supervision, training, governance and service improvement), and
- build in contingency for peaks, case complexity, interpretation needs and staff absence, with regular review to refine assumptions.

Physical requirements must also be added, including a dedicated, appropriate location and/or technology to facilitate telephone or video calls. Funding and protected time for clinical supervision is vital to support midwives delivering this service effectively and sustainably.

Training and development of staff

Understanding of the value of birth conversations should begin as part of pre-registration (undergraduate) education. Once qualified, it is essential that midwives who are undertaking birth conversations receive specific, comprehensive training and ongoing development opportunities. Training content should be reviewed and agreed by local services but should, as a minimum, cover trauma-informed practice, active listening, perinatal mental health, triage and safeguarding. Midwives should also receive training in understanding post traumatic stress symptoms to support assessment of the need for further psychological support.

The role may fall within the remit of an individual, or preferably with a team of midwives with a specific interest.

Midwives should receive training in techniques that can help women with emotional containment and strategies to reconnect at the end of their appointment, for example mindfulness and grounding. Birth conversations can be enriched by midwives having an enhanced understanding of the way trauma impacts a person and their behaviours in order for the midwife to reassure the woman to have insight into their feelings and behaviours.

Supervision and aftercare of staff

Supporting women to explore their birth experience – particularly in cases involving birth trauma – undoubtedly has an emotional impact on the midwives themselves. There is a risk of moral injury and vicarious trauma. Midwives who undertake birth conversations need regular opportunities for clinical supervision or support from an appropriately trained professional. Professional Midwifery Advocates (England), Clinical Supervisor for Midwives, Consultant Midwives or Clinical Psychologists can all have a role in supporting midwives.

Equality, inclusion and diversity considerations

Evidence shows that outcomes are worse for Black and Asian women, those living in more deprived areas and women living with multiple disadvantage[7]. There must be equitable access to birth conversation services for all women, in all their diversity, which requires thoughtful consideration of the individual needs they present with.

Service providers must incorporate measures into their planning to promote equity for women requiring interpreting services, those affected by digital literacy challenges or digital poverty, women with neurodivergent-specific needs, and individuals who may lack the knowledge and capacity to effectively navigate healthcare systems. There should be proactive efforts to promote the services to women who may require additional support in accessing birth conversation services. Women, particularly those experiencing severe and multiple disadvantage, may benefit from a nominated person, such as a care navigator, to assist them in accessing services positively.

Formal escalation and referral pathways

Effective engagement between birth conversation services and other professionals is essential to promote seamless communication and ensure clear, coordinated referral processes. Midwives working within their scope of practice cannot and should not offer psychological diagnoses or treatment for women displaying signs of post-traumatic stress disorders or other mental health issues. Providers should establish what existing maternal mental health services are available in the local area and develop clear referral pathways.

For women who have urgent risk, for example those who demonstrate severe distress, suicidal ideation, psychosis or safeguarding concerns, it is important for midwives to follow their local crisis or escalation pathways immediately rather than wait for routine Maternal Mental Health Services.

Integrated services

A multidisciplinary approach to birth conversations can be important to meet the varying needs of women. Other professionals may be well placed to support midwives undertaking birth conversations, depending on their needs. The expertise of obstetricians, neonatologists or anaesthetists and others' expertise can enrich birth reviews for women when working alongside midwifery specialists.

Section 2: Personalising care for a birth conversation

Trauma informed

It is important that all staff have a trauma informed approach throughout the maternity care continuum – trauma-informed practice aims to increase practitioners' awareness of how trauma can negatively impact on individuals and communities, and to reduce the negative impacts of trauma experiences to improve mental and physical health outcomes[3]. Furthermore, working in a trauma-informed way can transform people's experiences, enable those living with the impact of trauma to seek support and empower people through that process. Trauma-informed practice in maternity settings seeks to reduce the rate of women who experience trauma related to their birth, and to minimise the possibility of maternity care retraumatising women who have previously experienced any form of trauma. Trauma-informed practice includes active listening and empathy, cultural competence and sensitivity, establishing feelings of safety, building trust, transparency, empowerment, emotional regulation, collaboration, the ability to recognise trauma symptoms and making appropriate referrals, among others.

It is essential that midwives and others undertaking birth conversations with women are trained in and practice in a trauma-informed way. The principles of trauma informed working should be deeply embedded into the service.

Person centred

Ensuring that care is person-centred requires careful attention to the practical aspects of a birth conversation (further detailed in section 3). It is important to clarify the aims of the conversation with each woman individually and that the conversation is woman-led. Motivations for seeking a birth review may vary; some women may experience trauma symptoms, some are seeking to understand more about aspects of their care and why things happened in the way they did, others have more complex circumstances and may have feelings of shame, anger or grief for antenatal care, births, or postnatal care that did not go as expected. As the first step on their journey towards making sense of their experience and healing, exploring a traumatic maternity care experience should be done at the pace and with goals that are set by the individual.

Active listening

Active listening is essential for improving communication and promoting trust. It is fundamental that women feel heard and understood in all birth conversations, as this can help to validate their feelings and any of the complex emotions they may be experiencing. Active listening supports women to feel safe, share concerns and ask questions. It is through active listening that misunderstanding is reduced, enabling women to have a deeper understanding of the events around their birth. Active listening enables midwives to accurately understand women's interpretation of events, the gaps in their understanding, and their needs, therefore allowing midwives to provide support in the most appropriate way for each individual. Discussing the birth experience with a midwife can provide reassurance and help remove any sense of perceived blame away from the woman.

Without exception, women attending a postnatal birth conversation need to feel heard and have their experiences fully acknowledged.

Build trust

For women to feel respected, heard, and safe to share their thoughts and feelings, it is essential that they have trust in the midwife who is supporting them in exploring their maternity experience. It should be acknowledged that for women who have experienced trauma, developing a trusting relationship with a maternity care professional can be a challenge. Many women who have experienced trauma can feel vulnerable or fearful of services and professionals, and many will have experience of their trauma being overlooked, ignored or dismissed by such services or professionals in the past. Mistrust of midwives and other professionals who work within maternity services can be common, though continuity of carer can facilitate improved outcomes and a more positive and personalised experience for women. Midwives should be sensitive to the needs of women and allow adequate time to develop this relationship so as not to risk retraumatising women and to continue to deliver supportive care to women and families[4].

Collaborate with women

A birth conversation should not be used for any purpose other than a supportive means of exploring events and a woman's feelings around her pregnancy, birth or postnatal experience. Approaching birth conversations in collaboration with women, rather than in opposition or in defence of the provider organisation and/or staff providing the care is counterintuitive to the purposes of the meeting.

Using a birth conversation to offset a complaint, or as a precursor to a legal process is inappropriate and risks further traumatising women at a vulnerable time. A birth conversation is not a substitute for the duty of candour or the formal complaints process. If a woman wishes to make a formal complaint or pursue legal proceedings they should be supported to do so concurrently as an entirely separate process, without it affecting the emotional support she needs to explore and process her traumatic birth experience.

Compassionate

Compassionate care is essential to support and empower women to achieve the best possible birth according to her own wishes[5].

For women who received substandard care through their perinatal journey, it can be especially impactful when midwives demonstrate high levels of compassion during their birth conversation.

Compassionate practice is fundamental to building trust so women can express their thoughts and concerns, and to process any feelings of grief associated with her traumatic birth.

Sensitive approach

It is necessary for midwives and other professionals undertaking birth conversations with women to be sensitive to the varied emotions that women may be experiencing. Trauma can impact the ability to communicate; it can impede the ability to express thoughts, feelings and emotions, affect understanding, or limit the ability to engage in interactions with professionals.

Women with significant trauma may have difficulty with emotional regulation due to flashbacks or intrusive thoughts. This is an indicator that women may require more specialised support for which onward referral is necessary.

A sensitive inquiry into a woman's feelings around her birth experience can be a helpful way to start the conversation.

Validation

Validating a woman's experience is vital to enable her to feel heard and understood. For women who have experienced a loss of control during the perinatal period, it is important that their feelings about their antenatal care, birth and postnatal care are recognised and acknowledged with respect given to how she experienced her birth and that women are given the time they feel they need to explore those experiences and feelings.

Section 3: Practical considerations

Information and access for women

There should be a very clear process for all women to book, attend or access information about an appointment for a birth conversation. Services should be organised such that the process to birth conversations are clearly advertised, the booking process is clear and easily navigated for both women and staff. Staff-facing guidance and public-facing information should be consistent so women and referrers know who can refer, how to refer and the expected timeframes.

Eligibility and thresholds

If local services establish specific criteria that women must meet to qualify for a birth conversation appointment these criteria must be clear to prevent women being misled to believe it is available to them when it is not. Where capacity allows, a birth conversation should be available to all women who request one.

The threshold for reporting birth as traumatic should be defined by the women, not the clinicians. A birth that may be considered 'good' from a clinical perspective can still be experienced as deeply traumatic by the woman and her birth partners. A woman's account of her birth and her feelings about it should be validated, respected and believed.

Referrals

All professionals who care for women and families should be able to refer into the birth review service, at any point during pregnancy (either current or subsequent pregnancies) and the postnatal period. This includes from the neonatal unit as some women are traumatised through events related to a prolonged or unexpected neonatal unit admission. Collaboration across organisational boundaries may be necessary when women are referred by a neonatal unit located in a different trust or health board from where the birth occurred. Clear referral pathways should be established between trusts and health boards within a region to ensure seamless support.

Services should determine if women are able to self-refer and ensure this information is clearly communicated to women. The self-referral process should be easy to navigate and meet women's language and accessibility needs. Self-referral should be one option, but it should not replace the responsibility of professionals to identify women who may benefit from a birth conversation and refer them to local services. It is important to recognise that some women may lack the confidence, literacy or ability to complete the referral process themselves.

Person who undertakes the conversation

Consideration should be given to who the most appropriate person is to undertake the birth conversation with each woman. This should be personalised to and made in collaboration with each woman. The woman may have a preference for speaking with a midwife she already knows, such as a case load midwife with whom she has an established relationship.

There may be occasions where a woman's concerns relate to the midwife offering the birth conversation. In such cases, it would be inappropriate for that midwife to lead the discussion, as it may inhibit both the woman and midwife from having an open discussion. Efforts should be made to work with the woman to establish who would be the best alternative in this situation.

A midwife undertaking the birth conversation who is unknown to the women may have to work harder to establish a trusting relationship, which could impact on the time available during an appointment.

Timing of the birth conversation

Evidence supports that the timing of the birth review should be a minimum of 6-8 weeks after the birth. The early postnatal period is a time of physical adaptation, recovery and the early processing of the birth experience. In the early weeks following birth, women may experience confusion, a sense of loss of control, and psychological distress which can be proportionate and part of a normal response. It is important to not pathologise common emotional reactions to birth.

Some women, however, do not request a birth conversation even when they want, or could benefit, from one. This could be because they do not know the service is available, feel fearful because of the trauma they experienced, lack support, or face other barriers. Women who live with birth trauma may not access birth conversations services for many years following birth. For many, a subsequent pregnancy might prompt women to seek help to process a previous birth. Certain life events may trigger the resurfacing of previously unresolved trauma, leading some women to seek a birth conversation months or even years after their maternity experience.

Services should endeavour to make birth conversations available to all women who want them, regardless of how long ago they gave birth. If local services determine that time-based restrictions are necessary, this must be made clear to both staff and women.

Administration

The administrative process surrounding a birth review has the potential to add to the stress and trauma women may have already endured during the perinatal period. Offering a personalised service requires the administrative processes and referring midwife to be adaptable to the needs of the woman. Efforts should be made to simplify and streamline the process, removing barriers and ensuring that services are structured to support women in accessing birth conversations at a time that feels right for them.

Practical considerations

Practical considerations should include:

- **Where and by what means a birth conversation will take place?**
  This should be woman led and individualised to each woman. As much as possible, services should aim to accommodate women's needs and preferences about if they would like a face to face, telephone or video call meeting. For women experiencing trauma symptoms, attending an appointment in the same hospital or ward where the traumatic birth took place may be retraumatising. Services should be mindful of this and offer alternative locations where possible. Where there are significant delays to an appointment, women should be communicated with in a sensitive and timely manner.
- **Who will be present?**
  Women should be encouraged and supported to bring a companion of their choice to the appointment, and this should not be limited by where the appointment happens. Birth partners should be included as much as women are comfortable with; they can be a support for women, sometimes bringing an additional perspective. Birth partners generally benefit themselves from discussing birth events.
- **Who to contact about the appointment?**
  Women should be provided with the contact details for the birth conversations service should they need to make contact ahead of or following their appointment. This is because issues around the changing or cancelling of an appointment are a further stressor.
- **What will happen during the appointment?**
  When providing a face-to-face appointment, services should pay particular attention to the reception and welcome that women receive on arrival. Women are likely to feel vulnerable, emotional and fearful at a birth conversation appointment. There should be clear signposting and designated area to wait ahead of the appointment. The welcome that women and their families receive is a crucial first step in building a trusting relationship and supporting the healing process after a traumatic birth. If women are met with negativity, hostility, or defensiveness, it can reinforce feelings of despair and can make them feel more unsafe.

Clarify the scope of the birth conversation

It is helpful for all parties – women, midwives, commissioners and others – to understand the scope and limitations of a birth conversation. Midwives should not be asked to work beyond the scope of their role and experience. All should be aware that a birth conversation is not a psychological treatment for people with a diagnosis of post-traumatic stress disorder, or a therapy to be used in a mental health crisis. Services must have a clear referral pathway for women who are identified as requiring further, specialised support or treatment, and these limitations and pathways must be discussed with each woman considering a birth conversation.

It can be helpful for the referring midwife to clarify with the woman their aims for the birth conversation, if they can articulate them; with this information shared on the birth conversation service referral form. Gentle enquiry into the questions women and their birth partners may have can help set realistic expectations about what can be achieved within the scope of a birth conversation.

Preparation for the conversation

It can be helpful for women to have the opportunity to write their questions, thoughts and reflections before meeting with a midwife to discuss their birth. Similarly, midwives should have the opportunity to review the birth records in advance to understand the context before meeting the woman. This work may also involve speaking with other professionals – such as anaesthetists, neonatal staff or obstetricians – in order to be fully prepared to answer the specific questions the woman may have.

Documentation and follow up

Those who provide the birth conversations service should identify how they will document the birth conversation appointment and how it can be securely stored and accessed if necessary.

With the woman's consent, it is helpful to provide a written summary of the birth conversation to her, her GP and health visitor, as well as recording it in the hospital notes. Other professionals involved in her case – such as community psychiatric nurses – may also benefit from receiving this summary.

Women may have difficulty retaining the information discussed during the birth conversation appointment. This may be due to being sleep deprived, those attending with their baby can be distracted, or women may feel overwhelmed and emotional during the appointment. For these reasons, it is important to give a written summary of the main points that were discussed, questions that were asked, the answers given and the woman's account of her feelings regarding her experience for her to refer to as she feels necessary.

Space for questions

At the end of the appointment, it can be helpful to explore any remaining questions the woman and her birth partners may have, as well as their feelings around what was discussed. Services should clearly communicate whether only one appointment is offered to each woman, or if additional sessions are available upon request.

Women should be encouraged to discuss all their questions, including medical, psychological and other. The midwife should be clear about which questions she is able to answer and which may indicate the need for psychological therapy, requiring onwards referral.

There may also be occasions when the midwife requires input from a specialist in order to answer specific questions – for example, a consultation with a medical professional. In such cases, the woman should be informed, and appropriate follow-up should be arranged as needed.

Containment

For some women, it is important to include a grounding strategy at the end of the appointment. After a woman has allowed herself to be vulnerable and opened up about her traumatic experience, midwives can help her reconnect with the present moment by using strategies such as sensory engagement, mindfulness or positive affirmations.

Aftercare

Exploring how a woman feels at the end of the birth conversation can help midwives identify those who require further support or onwards referral. Women should be reassured that they are in a safe place as they discuss their plan for after the appointment and to identify any ongoing needs.

Women should be clear about their options after the appointment, if there is the option of a follow up appointment, or where to seek more support if this is not available within the commissioned service. It can be helpful to provide women with a resource sheet that details local support services.

System learning

There may be opportunity for service improvement because of the insights provided by women during birth conversations. There should be a clear feedback and learning mechanism to identify themes arising from birth conversations.

Integrating feedback from birth conversation with other sources of governance data - such as complaints, friends and family test responses, incident review investigations, requests for care outside of guidance, and input from patient experience leads and Maternity and Neonatal Voice Partnership representatives – can offer a more comprehensive understanding of service quality and user experience within local maternity settings. Reducing traumatic birth is essential to improving women's experiences of maternity care.

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