Better Start BRADFORD 2015-2025

SHARING KNOWLEDGE, SHAPING FUTURES

Personalised Midwifery

Project Impact Report: 2025

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

Contents

About Better Start Bradford

Better Start Bradford is part of the ten-year A Better Start programme set up and funded by The National Lottery Community Fund in 2015.

Since 2015, A Better Start partnerships in Blackpool, Bradford, Lambeth, Nottingham and Southend-On-Sea have supported families to give their babies and very young children the best possible start in life, specifically to:

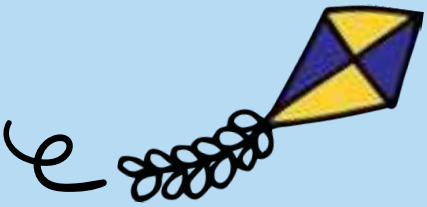
- Improve children's diet and nutrition to support healthy physical development and protect against illness in later life.
- Support children to develop social and emotional skills so they can develop positive relationships and cope with difficult situations.
- Help children develop their language and communication skills, so that they can engage with the world around them. Help children develop their language and communication skills, so that they can engage with the world around them.
- Bring about changes in systems, practice and behaviour that increased the focus on the first 1001 days of life and invest in preventative and early intervention approaches that have been demonstrated to have impact.

In Bradford, we created over 20 evidence-led projects and services for expectant families and families with children aged 0-3 in Bowling and Barkerend, Bradford Moor and Little Horton (the Better Start Bradford area).

Each one was designed with, and for, our specific communities, delivered by commissioned partner organisations, and evaluated throughout by the Better Start Bradford Innovation Hub (BSBIH).

Better Start Bradford set up the Innovation Hub with Born in Bradford at the Bradford Institute for Health Research (BIHR) to be our evaluation partner for the whole programme. We also commissioned the additional birth cohort, Born in Bradford Better Start (BiBBS), to allow a more extensive and longer-term evaluation. The findings of the BSBIH evaluation of each of the projects are threaded through these Impact Reports and are credited to BSBIH.

This work has been supported by complementary strands of work, including community engagement, workforce development, campaigns and volunteering.



The Personalised Midwifery Project

Personalised Midwifery is an approach to maternity care that tailors support to the unique needs, preferences, and circumstances of each woman and her family. The Personalised Midwifery Project was commissioned by Better Start Bradford between October 2015 and March 2024, with a pause between April 2020 – September 2020 due to the COVID-19 pandemic.

Personalised Midwifery is:

- **Continuity of care:** Women are supported by the same midwife, or small team of midwives, throughout pregnancy, birth, and the postnatal period.
- **Woman-centred:** Care plans are based on individual choices, cultural considerations, and medical needs.
- **Holistic support:** Addresses physical, emotional, and social wellbeing, including mental health, breastfeeding, and lifestyle factors.
- **Improved communication:** Longer, more personalised appointments help build trust and confidence between women and their midwives.
- **Better outcomes:** Research shows personalised midwifery improves maternal satisfaction, reduces medical interventions, and enhances birth experiences.

This approach is especially beneficial for women from vulnerable or disadvantaged backgrounds, ensuring equitable access to high-quality maternity care.

Why the Personalised Midwifery Project was needed

Women in socially disadvantaged communities, particularly in ethnic minority groups, face significant inequalities in maternity care, leading to higher risks of poor birth outcomes and perinatal mental health issues. Bradford's infant mortality rate is almost double the national average, with rates particularly high in the Better Start Bradford wards of Bowling and Barkerend, Bradford Moor, and Little Horton (BIRU, 2020).

Key challenges leading to the need for the Personalised Midwifery Project

- **High levels of socioeconomic deprivation**
  The Better Start Bradford area includes some of the most deprived wards in Bradford, where families face poverty, unemployment, and housing instability. Studies from the Born in Bradford Better Start cohort (BiBBS) have shown that lower socioeconomic status is linked to poorer pregnancy and perinatal outcomes (Prady et al., 2021; Elhakeem et al., 2024) as these stressors can negatively impact maternal and infant health.
- **Ethnic minority populations and health inequalities**
  The Better Start Bradford area has a highly diverse population, with a significant proportion from ethnic minority backgrounds. Women in these communities may experience discrimination, language barriers, and unequal access to healthcare, increasing stress levels and negatively affecting health outcomes. Research shows that ethnic minority women are twice as likely to have undiagnosed or untreated common mental health disorders compared to White British women (Prady et al., 2021).
- **Higher infant mortality rates**
  Bradford has one of the highest infant mortality rates in England. The infant mortality rate in Bradford is 6.6 per 1,000 live births, compared to the national average of 3.9 per 1,000, with even higher rates in some Better Start Bradford wards (BIRU, 2020). In Bradford City, the rate reaches 24 per 1,000, highlighting extreme health disparities and the urgent need for targeted maternity interventions.
- **Perinatal mental health inequalities**
  Women in socially disadvantaged circumstances are less likely to have their mental health issues, such as depression and anxiety, identified or adequately addressed. Research shows that perinatal mental health conditions often go undiagnosed and untreated among women from low-income and ethnic minority backgrounds, increasing the risk of poor maternal-infant bonding and delayed child development (Prady et al., 2021). The Maternal Mental Health Alliance (2023) highlights that Black and Brown women, young mothers, and those experiencing multiple disadvantages are at greater risk of mental health problems and are less likely to receive the care that they need.
- **Increased stress and discrimination**
  Women in the Better Start Bradford area are more likely to experience chronic stress, social exclusion, and systemic discrimination, all of which are linked to poorer mental and physical health outcomes (Prady et al., 2021). These factors further widen the health inequalities faced by women in these communities.

These factors emphasised the necessity of the Personalised Midwifery Project in the Better Start Bradford area, highlighting the complex challenges that contribute to poor birth outcomes and perinatal mental health difficulties among local families. In the long term, the project aimed to deliver holistic benefits for children of mothers supported by the Personalised Midwifery Project. These included improved developmental trajectories that would help reduce inequalities from birth, as well as positive lifelong outcomes such as enhanced language and social skills, stronger parent-infant interactions, and lower rates of childhood obesity.

In addition to local evidence, parent journey mapping revealed that women in the Better Start Bradford area frequently delayed engagement with antenatal care, had low attendance at antenatal classes, and often presented later in pregnancy. Other issues included fragmented maternity care with multiple handovers, leading to inconsistent advice and support.

Women from the Better Start Bradford area, particularly those from minority ethnic backgrounds, reported dissatisfaction with their maternity care experiences, including feelings of being unheard, cultural insensitivity, and insufficient emotional and mental health support. Moreover, disparities in maternal and neonatal outcomes were evident, including higher rates of preterm births and low birth weight among women in the Better Start Bradford area compared to district averages. Women expressed a need for continuity, personalised care, and better emotional support throughout their maternity journey.

Service design

The Personalised Midwifery Project was co-designed with researchers from the Better Start Bradford Innovation Hub, alongside input from mothers, families, health professionals, and community representatives. The design addressed key priorities identified through consultation:

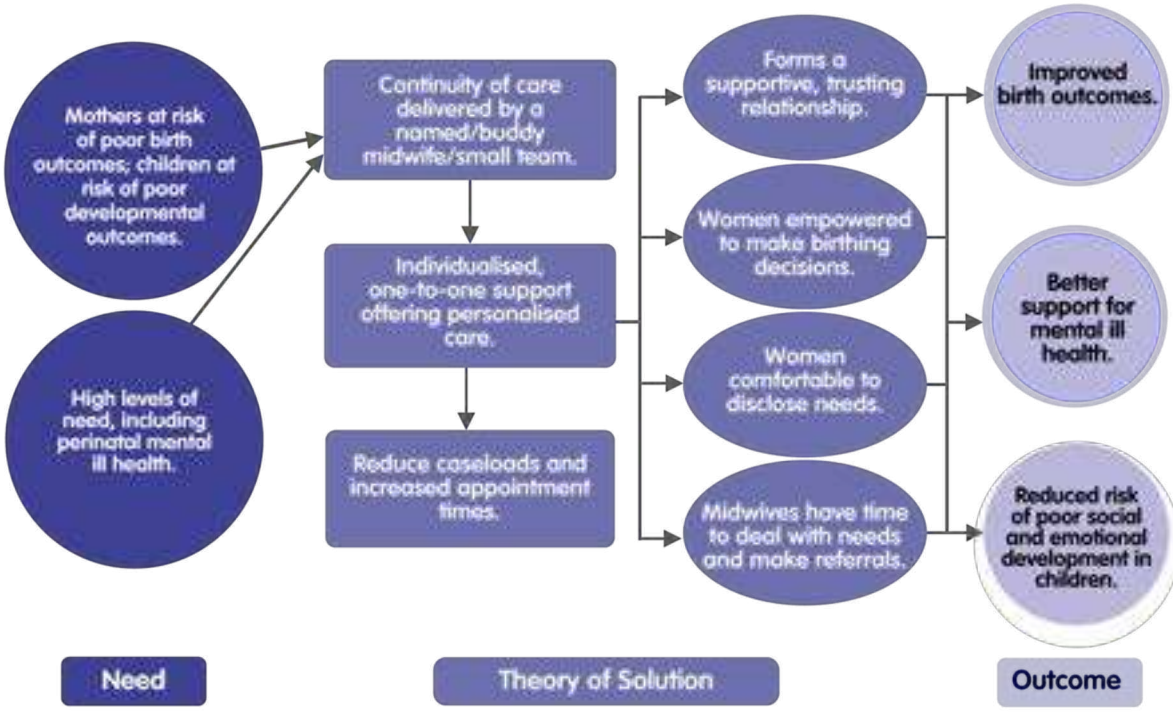
- **Continuity of care:** strengthening trust and communication between women and midwives.
- **Culturally sensitive care:** tailored support for the diverse needs of the community.
- **Emotional & mental health support:** addressing perinatal wellbeing.
- **Improved accessibility:** flexible appointment times and home visits.

Theory of Change and Logic Model

We used a Theory of Change and Logic Model approach to design our services. These are included in the impact report because they offer a useful summary of the service design. They are accompanied by an evaluation plan which is delivered by the Better Start Bradford Innovation Hub.

The Theory of Change explains how we have identified a need (for example poor health) for improved outcomes and why we believed the proposed service would provide a solution (based on evidence and science). The Logic Model shows the steps we needed to take to arrive at the desired outcomes. It identified the need, the target group(s), the inputs and activities which would impact on the outcomes and the changes we should expect to see in the short, medium and long term.

Personalised Midwifery Project: Theory of Change



Logic Model: Personalised Midwifery Project

Risks	Intervention	Change Mechanisms	Short term outcomes	Medium term outcomes	Long term outcomes
Limited engagement with antenatal care and maternity services.	Personalised Midwifery Pilot	Enhanced antenatal support.	Women empowered to make more informed choices.	Reduced smoking rates, increased rates and improved antenatal nutrition.	Better maternal mental health.
Poor antenatal health and nutrition.		Continuity of care and relationship with midwife.	More time to discuss key Public Health messages antenatally.	Fewer low birth weight babies/fewer babies born preterm.	Improved developmental outcomes for children.
Low birth weight and poor birth outcomes.			Great engagement with maternity services and earlier booking.	Women have fewer antenatal admissions.	Improved engagement with other services.
Maternal depression, poor bonding and attachment.		Support and co-ordination of care for high risk women.	Women have a more positive experience of birth and greater satisfaction with antenatal care.	Babies may have fewer neonatal admissions.	Reduced childhood obesity.

Key components

The Personalised Midwifery Project was built on a midwife-led continuity of care (MCC) model, designed to provide consistent, relationship-based care throughout the antenatal, intrapartum, and postnatal periods to enhance maternity services through structured appointments and personalised support. Midwives attended births, where possible, and continued to provide postnatal care, ensuring seamless support.

The Personalised Midwifery Project key components included:

- **Continuity of care:** Women received care from a named midwife or a small MCC team during antenatal, intrapartum, and postnatal periods. Midwives attended births where possible and continued to provide postnatal care, ensuring seamless support during the critical postpartum period.
- **Smaller caseloads:** Midwives had fewer women to care for, allowing for longer, more personalised appointments.
- **Flexible and accessible care:** Appointments were tailored to women's needs, including home visits and longer consultations. Personalised care plans were developed during one-to-one appointments to address individual needs and preferences.
- **Culturally sensitive approach:** To better understand and meet the needs of the diverse population, particularly when supporting ethnic minority and disadvantaged women.
- **Enhanced mental health support:** Midwives were trained to identify and support perinatal mental health issues, and referrals were made to appropriate services when needed.
- **Integration with community services:** Midwives worked closely with other Better Start Bradford projects, prevention and early intervention services to ensure holistic maternity care.

What was the offer and how did it work?

Pregnant women living in the Better Start Bradford and Reducing Inequalities in Communities (RIC) postcodes were enrolled in a randomised controlled trial (RCT) to assess the impact of the Personalised Midwifery Project on birth outcomes and perinatal mental health. Participants were randomly assigned to either standard maternity care provided by existing community midwifery teams or continuity of care from a named midwife or her buddy within the Clover Team, a dedicated midwife-led continuity of care (MCC) team. The antenatal, intrapartum, and postnatal care was delivered with a strong focus on flexibility, personalisation, and relationship-based support to enhance maternity experiences and improve health outcomes.

Phased Implementation

The Personalised Midwifery Project had a phased implementation:

Phase 1: Pilot & feasibility study (2017-2019)

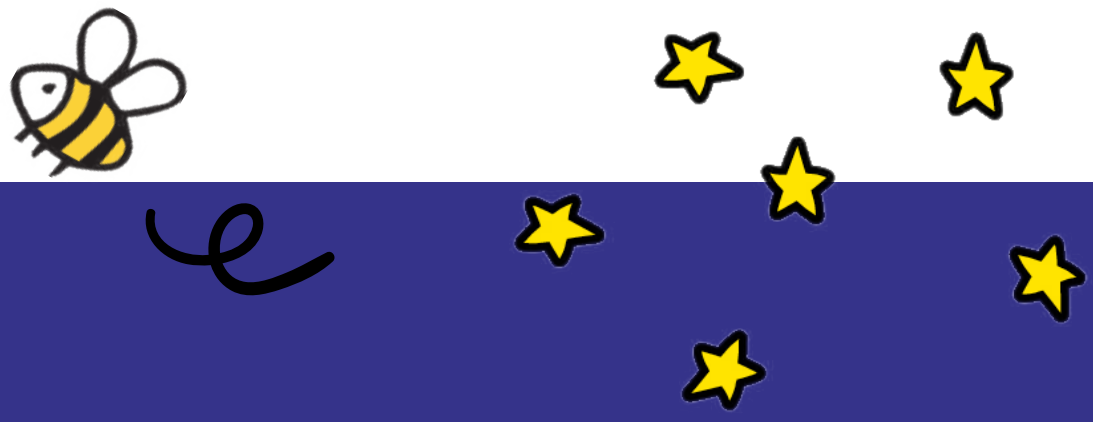
- Assessed the practicality and acceptability of the continuity of carer model.
- Evaluated midwives' and women's engagement with the model.

Phase 2: Expansion (2019-2021)

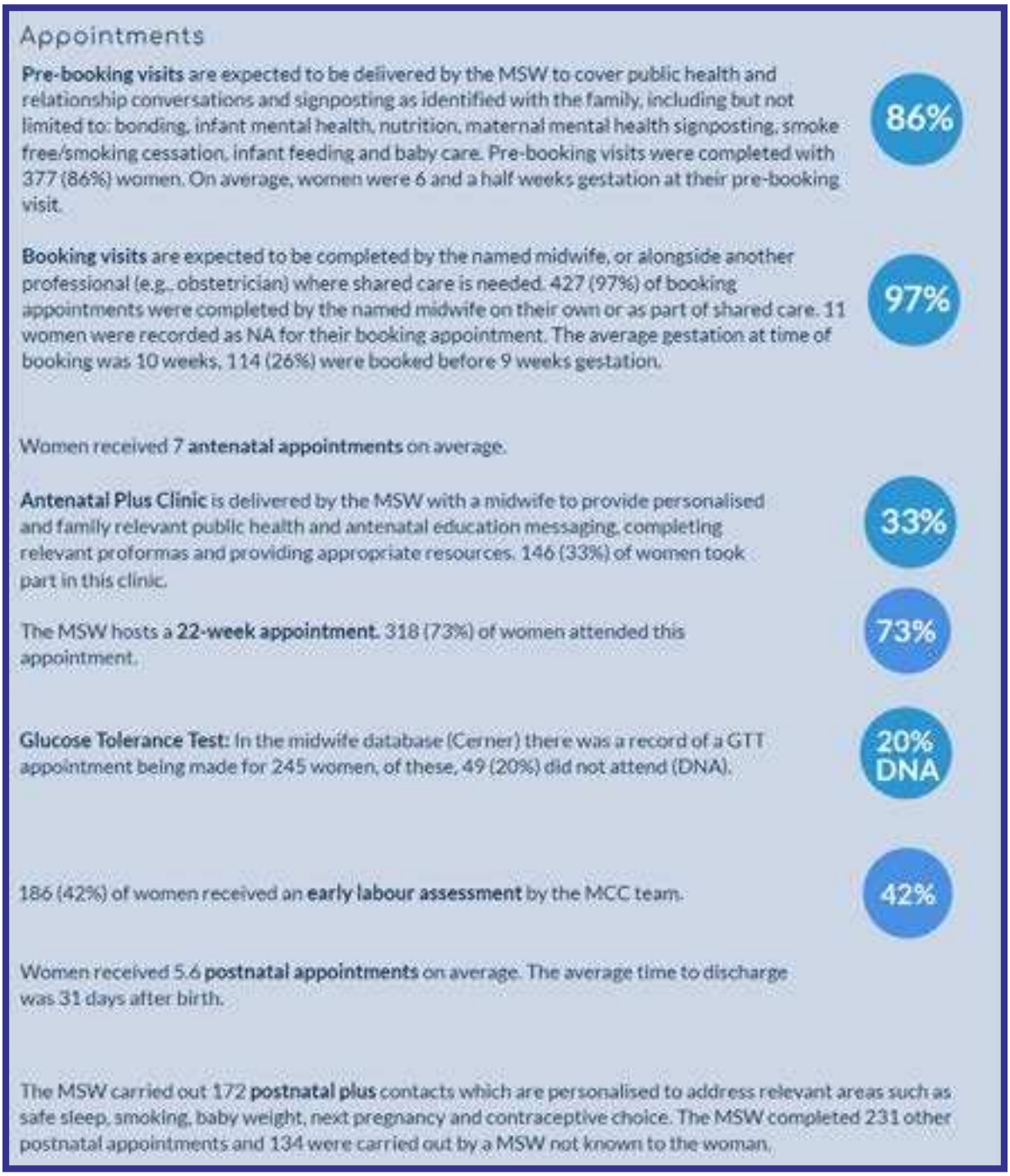
- Delivered by the Opal Team at St Luke's Hospital.
- Ensured at least 70% of maternity care was provided by a named midwife or buddy.
- Introduced longer appointments, home labour assessments, and extended postnatal care (up to six weeks).

Phase 3: Scaling up & enhanced evaluation (2021-2024)

- Delivered by the Clover Team at St Luke's Hospital.
- Introduced a tripartite funding model (Better Start Bradford, Reducing Inequalities in Communities (RIC), and Bradford Teaching Hospitals NHS Foundation Trust).
- Embedded personalised care plans, where women could choose appointment frequency and birth location.
- Included a randomised controlled trial (RCT) to measure impact on birth outcomes, particularly for socially disadvantaged women.



The extract below from the Better Start Bradford Innovation Hub implementation evaluation features some of the key findings around antenatal and postnatal appointments.



Appointments

Pre-booking visits are expected to be delivered by the MSW to cover public health and relationship conversations and signposting as identified with the family, including but not limited to: bonding, infant mental health, nutrition, maternal mental health signposting, smoke free/smoking cessation, infant feeding and baby care. Pre-booking visits were completed with 377 (86%) women. On average, women were 6 and a half weeks gestation at their pre-booking visit.

86%

Booking visits are expected to be completed by the named midwife, or alongside another professional (e.g., obstetrician) where shared care is needed. 427 (97%) of booking appointments were completed by the named midwife on their own or as part of shared care. 11 women were recorded as NA for their booking appointment. The average gestation at time of booking was 10 weeks, 114 (26%) were booked before 9 weeks gestation.

97%

Women received 7 **antenatal appointments** on average.

Antenatal Plus Clinic is delivered by the MSW with a midwife to provide personalised and family relevant public health and antenatal education messaging, completing relevant proformas and providing appropriate resources. 146 (33%) of women took part in this clinic.

33%

The MSW hosts a **22-week appointment.** 318 (73%) of women attended this appointment.

73%

Glucose Tolerance Test: In the midwife database (Cerner) there was a record of a GTT appointment being made for 245 women, of these, 49 (20%) did not attend (DNA).

20% DNA

186 (42%) of women received an **early labour assessment** by the MCC team.

42%

Women received 5.6 **postnatal appointments** on average. The average time to discharge was 31 days after birth.

The MSW carried out 172 **postnatal plus** contacts which are personalised to address relevant areas such as safe sleep, smoking, baby weight, next pregnancy and contraceptive choice. The MSW completed 231 other postnatal appointments and 134 were carried out by a MSW not known to the woman.

Key project aims

The Personalised Midwifery Project launched its pilot phase in 2015, aiming to improve maternity care through enhanced antenatal and postnatal support. Initially operating with a small team of community midwives to provide midwifery-led continuity of carer (MCC) based within the Better Start Bradford area at St. Luke's Hospital. The Personalised Midwifery Project demonstrated early outcomes, including better access to maternity care, fewer missed appointments, and improved maternal mental health.

Short, medium, and long-term goals

Short term

- Increase breastfeeding rates at discharge.
- Improve maternal and newborn health outcomes.
- Enhance early maternal mental health support.
- Strengthen integration with Better Start Bradford and Reducing Inequalities in Communities early years programmes.

Medium term

- Increase babies exclusively or partially breastfed up to six months.
- Reduce maternal anxiety and depression.
- Improve early bonding and infant emotional development.
- Strengthen relationships with ethnic minority & low-income families to improve access.
- Demonstrate successful model replication across wider areas.

Long term

- Ensure holistic benefits for children of Personalised Midwifery Project.
- Improve developmental trajectories, reducing inequalities from birth.
- Influence lifelong outcomes, leading to better language and social skills, improved parent-infant interactions, and lower childhood obesity rates.

This structured, evidence-driven approach ensured the Personalised Midwifery Project improved maternal experiences, birth outcomes, and long-term child development, providing a model for national maternity care transformation.

A summary of the qualitative research findings from the Better Start Bradford Innovation Hub is below.

	Model	Women	Midwives
Phase 1 (partial; midwife/ buddy) October 2015 - February 2019	Key components identified: • Reduced caseload. • Appointments could be made longer. • Flexible working. • Team cohesion and stability. • Maternity Support Worker (MSW). • Administration Support.	Greater satisfaction in MCC than SC. Qualitative evidence suggests this model improved perinatal mental health: • Women reported they had trust in the midwife to share problems. • Midwives felt they had the time to ask, and to deal with any issues identified and reported the value of being able to build trusting relationships and visit women at home which allowed them to identify mental health and domestic violence concerns.	MCC midwives: • High levels of job satisfaction. • Reduced stress. • Increased role fulfilment. Traditional care midwives: • Feelings of stress and burnout due to time pressures. • Lack of role fulfilment.
Phase 2 (full; midwife/team) March 2019 - February 2020	Key components identified: • Smaller caseloads. • Upskilling the MSW (pre-booking visits, baby care, bloods, etc., freed up midwives' time). • Scheduling appointments to correspond with translator availability. • Team cohesion and stability. • Clover midwives felt supported by staff on the labour wards.	High levels of satisfaction in MCC. Further supportive evidence of impact postnatally: • Midwives felt the model promotes women's welfare and that the trusting relationship allowed women to disclose mental health issues earlier. • Continuity in the postnatal period promoted disclosure, identification and monitoring of women's mental health needs. • Women felt well supported and felt able to talk about their mental health with their Clover midwife.	• MCC reported supporting women during the intrapartum period was the most difficult part of the model but did not feel this was detrimental to women. Tensions between MCC and labour ward were due to: • MCC acknowledged a competency deficit in community midwives which put a strain on existing resources. • Midwives at the birth centre do not always call the MCC, especially when women say they are happy with the core team.

Summary of the qualitative research findings from Phase 1 and 2

	Antenatal Continuity	Intrapartum Continuity	Postnatal Continuity
Phase 1 (partial; midwife/ buddy) October 2015 - February 2019	94%	N/A	70%
Phase 2 (full; midwife/team) March 2019 - February 2020	100%	63%	92%

Summary of the level of continuity* achieved in the Better Start Bradford supported models of MCC, phases 1 and 2.

Continuity* was defined as women receiving >70% of their care antenatally/postnatally as per MCC model and had a MCC team member present during labour and/or birth.

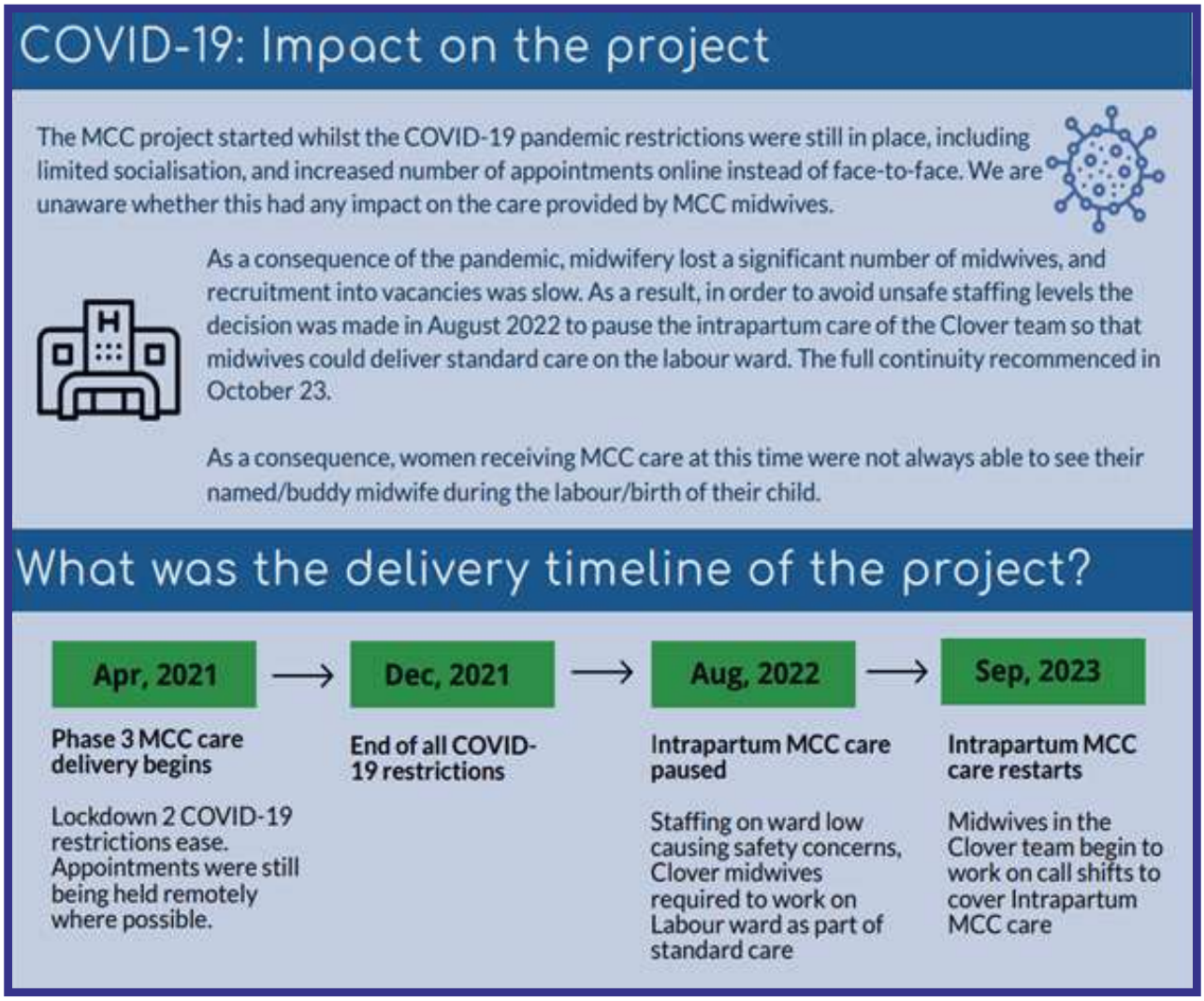
COVID-19

COVID-19 had a significant impact on the delivery of the Personalised Midwifery Project, affecting staffing, service provision, and continuity of care. Key challenges included disruptions to intrapartum care as the Clover Team were required to support the labour ward, leading to the pause of intrapartum continuity of care in August 2022. This meant that many women receiving Personalised Midwifery Project care did not have their named midwife present during labour and birth, causing a gap in the full continuity of care model. Intrapartum continuity was reinstated in October 2023, once midwifery staffing allowed.

National midwifery shortages, worsened by the COVID-19 pandemic, meant only one Midwifery Continuity of Care team (The Clover Team) was established instead of the planned two. Midwives across the service faced increased workloads, leading to stress and burnout, which further impacted service sustainability. Social distancing measures led to more virtual appointments instead of in-person consultations. While this allowed services to continue, it reduced face-to-face interactions, which are key for building trust, assessing maternal wellbeing, and providing hands-on support.

The pandemic delayed the expansion of Personalised Midwifery Project services and impacted the ongoing evaluation, particularly the randomised controlled trial (RCT). Some postnatal visits and mental health support may have been less effective due to restrictions on home visits.

Despite these challenges, the Personalised Midwifery Project adapted by maintaining high antenatal and postnatal continuity rates, ensuring that women still received consistent, relationship-based care. The pause in intrapartum care and staffing shortages affected the full implementation and evaluation of the continuity of care model.



Data and evaluation

The Personalised Midwifery Project was evaluated through data analysis and qualitative research over the duration of its delivery by the Better Start Bradford Innovation Hub.

The final phase of the research will need a number of women to go through their full maternity care with the Personalised Midwifery Project, taking a minimum of 18-24 months. Following this quantitative analysis, the full findings will be produced in 2025 as an effectiveness report to supplement the qualitative report with interim findings and will detail the impact that the service has had on birth and mental health outcomes.

The evaluation of the Personalised Midwifery Project assessed its implementation, continuity of care, patient experiences, and outcomes. Below is a summary of the key data and evaluation, impact and findings, economic and social impact, and future recommendations to date.

Data quality and implementation evaluation

Data quality

The maternity team at BTHFT have been very supportive of this evaluation. They have worked closely with the data team within the BSBIH to provide us with the necessary data, access to women and midwives for the qualitative work and randomisation for the RCT.

Implementation Evaluation

The aim of the MCC project was to provide two teams of 7 WTE midwives and provide care to 1,260 women over 36 months. However, due to the impact of COVID-19 and national staffing issues, only one maternity team was implemented. The remainder of this report focuses on the implementation of this single team - Clover. Targets have been reduced to those expected for a single team. Data reported are from 1st April 2021 - 31st July 2023 (28 months) and targets have been amended to this time period.

Key Findings

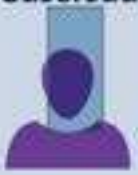
This appendix provides an update to the Continuity of Carer Phase 3 End of Contract Report (November 2023) to include final numbers from the evaluation of the project. The numbers presented include all project data collected between 1st April 2021, when delivery started, to 29th February 2024 when the project finished enrolling women to the model. It should be noted that while women recruited to the model were expected to receive continuity of care for the reminder of their maternity journey, the team were disbanded in September 2024. This means women enrolled in January and February 2024 did not have the opportunity to receive full continuity.

Recruitment

585 women supported

Recruitment refers to the number of women supported by the Continuity of Care team. It was anticipated that the team would support 630 women across the duration of the service. The actual number supported was 585, 93% of the anticipated figure.

Caseload



Average caseload of 33 women

Across all delivery years the average caseload for midwives stayed below the maximum target of 35.In Year 1 average was 30, in Year 2 it was 30, and in Year 3 it was 33.

Levels of Continuity

ANTENATAL: 84% of all antenatal appointments were provided by the MCC team, with the majority (73%) delivered by the named midwife.

INTRAPARTUM: Only 80 births (14%) were attended by a midwife from the MCC team.

POSTNATAL: 67% of all postnatal appointments were provided by the MCC team, with 50% provided by the named midwife.

In total, **25 women received full continuity across their pregnancy** (>80% continuity antenatally and postnatally and having a known midwife present at birth).

The proportion of women receiving continuity in the antenatal and postnatal periods have reduced since the End of Contract report, presumably due at least in part to the disbanding of this team during 2025.

Recruitment and Reach

Ethnicity

Asian Pakistani (57%) White British (8%)
White Other (6%) Other (21%)
Other South Asian (8%)

The majority of women receiving MCC were of Pakistani heritage (57%).

Most women (67%) were aged between 25 and 34 years of age.

For 30% this was their first baby.

Age range of women

0 (30%) 1 (34%) 2 (20%)
3+ (16%)

Number of previous children (parity)

<24 (22%) 24-29 (36%) 30-35 (31%)
>35 (11%)

Impact and findings

The Personalised Midwifery Project had a positive impact on maternity care by improving continuity, engagement, and satisfaction among women.

Positive impacts included:

- **Trust and relationship-based care:** Women valued having a consistent midwife, leading to stronger trust and communication. 92% of women felt the Clover Team always supported their health during pregnancy.
- **Improved access and engagement**: The flexibility of care (home visits, longer appointments) encouraged better engagement with maternity services.
- **Personalised and culturally sensitive care:** Women from ethnic minority backgrounds found the model particularly beneficial.
- **High-quality antenatal and postnatal care:** Despite challenges, the midwifery-led continuity of carer (MCC) team maintained strong antenatal and postnatal continuity.

Challenges identified:

- Staffing shortages led to burnout risks and limited intrapartum continuity, affecting staff retention and job satisfaction.
- Inconsistent managerial support made it difficult for midwives to adhere fully to the MCC model. Some midwives felt unsupported in delivering the full MCC model.
- Intrapartum continuity was paused in August 2022 due to staffing challenges and resumed in October 2023.

Lessons learned:

- Strong leadership and system-wide support are essential for sustainability.
- MCC can work effectively in deprived areas but needs stable funding and staffing.
- Integration with hospital-based maternity teams is critical for continuity at birth.

Qualitative evaluation

The following extracts from the Better Start Bradford Innovation Hub summarises what women said about the support they received and a snapshot of the qualitative evaluation findings from midwives and team leaders.

Qualitative Evaluation

The aim of the process evaluation was to explore the experiences of both the midwives and team leaders delivering this model of care and the women who have recently been discharged after receiving this model of care.

To date (end of August 2023), 10 interviews have been completed and diaries completed by 2 midwives and 4 team leaders. The findings below present preliminary analysis of the first 6 interviews and all the diaries gathered to date.

Midwives and team leaders

Feasibility and facilitators of the model

Team leaders acknowledged the MCC model would not work without midwives that have **passion** and **dedication** for the model. All midwives and team leaders reported that the impact of staff shortages for the team was difficult. Team leaders reported on some of the specific strategies they were using to try and alleviate the **pressures** felt by midwives in their team.

"...the team consistently remain committed to ensuring full commitment to the model"

"I have tried to ensure the off duty gives them adequate time off to rest between shift..."

Staff acknowledged that they felt that their managerial team were not always supportive of the MCC model.

"I have felt that support from XXX has not been there, This makes me feel like we are constantly battling to promote continuity of carer with little support from higher management."

"We have also experienced negativity and an unwillingness to embrace continuity from many colleagues"

Qualitative Evaluation

Feasibility and facilitators of the model continued

Although both midwives and team leaders acknowledged staffing challenges and other barriers to providing care the team expressed **pride** in their work within the MCC model.

"Antenatal and postnatal care has been maintained [to] a very good standard throughout the whole of the operation of the team."

"...team members that have been left working within the team have still [put] 100% effort in...this should be recognised as a big achievement."

Some staff reported concerns for their fellow midwives with burnout being identified as a real possibility. This was primarily because of the difficulties staffing shortages were causing and team leaders referred to "staffing challenges and low morale" amongst their teams.

"The team believe their team dynamic have improved this quarter, this can be seen visibly..."

"Burn out has been a problem for us but we had a strategy planned to mitigate this unfortunately staff shortages have scuppered our plans."

"The model can only succeed if both the team and the unit it works within are fully staffed."

Staff stated that they did not think the team would be able to show long-term success with the MCC model provision until their team and the wider midwifery unit was fully staffed.

Local and national strategic influences

SCAN ME to view strategies

The Personalised Midwifery Project continues to align with local strategies:

- Bradford District Children and Young People's Strategy 2023-2025
- Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) Maternity Strategy 2020
- West Yorkshire Health and Care Partnership Maternity Programme Local Maternity and Neonatal System (LMNS) 2023
- Act As One - Every Baby Matters (City of Braford Metropolitan District Council (n.d.))

National strategic alignment is maintained with new NHS guidance including:

- Saving Babies Lives Care Bundle (NHS England 2023)
- The Three year delivery plan for maternity and neonatal services (NHS England 2023)
- NHS England (2021) Continuity of Carer
- The Core20plus5 for maternity and children and young people (NHS England 2021)
- NHS 10-Year Health Plan for England (2025)
- Best Start in Life Strategy (2025)

The Personalised Midwifery Project alignment with the strategies contributes to long-term outcomes such as:

- Better maternal and child health.
- Reduced health inequalities.
- Improved family wellbeing and mental health.

The project's social benefits include:

- Enhanced postnatal care helped support early attachment, stronger maternal-infant bonding and higher breastfeeding rates (64% initiated breastfeeding, 36% exclusively).
- Women reported greater confidence in managing their health and newborn care and felt more empowered in their pregnancy and birth decisions.
- Midwives found the model rewarding but reported burnout risks due to staffing shortages.
- The Personalised Midwifery Project strengthened relationships between women and healthcare providers, improving maternity service uptake and community trust in maternity services.

Recommendations for practice

- **Review system capacity for intrapartum continuity**
  Given the current challenges and low intrapartum continuity rate (14%), a thorough review of providers' capacity to deliver intrapartum care, alongside antenatal and postnatal continuity, should be undertaken once full continuity has been re-established and sustained.
- **Address workforce constraints**
  To mitigate the risk of midwife burnout and ensure the effectiveness of the continuity model, efforts should be made to secure adequate staffing levels within MCC teams. Workforce planning should prioritise stability to support continuity of care.
- **Balance model ambition with system resilience**
  Any expansion or continuation of a full continuity model, including intrapartum care, should be carefully weighed against system stability, workforce capacity, and the wellbeing of both women and midwives.

As part of the qualitative evaluation from the Better Start Bradford Innovation Hub, interviews with women were held and the following key themes were identified:

Trust

Many women believed they had the opportunity to share their feelings, with many saying that they had opened up about mental health concerns or difficulties with their midwives.

> "I remember when I had the baby and I was feeling a bit low in myself, she stayed a lot longer with me, just to sit with me and talk to me and that just made the day for me."

> "I trusted her to kind of listen to me and help me through it."

Relationship

Women spoke openly about the bond they formed with their main midwife.

> "I remember one of the appointments, because I was a little overwhelmed, she stayed a little longer."

> "It wasn't just like a midwife, it was like a family member type of midwife."

Convenience and adaptability

The model seemed to offer many benefits to women, with many stating that they were grateful to have had their antenatal and postnatal appointments at home.

> “It was a lot easier because they came to me and I wasn’t trailing out to the doctors all the time to see them and it was more comfortable with being at home.”

> “She was really flexible as well because whenever I asked her, I can’t do this day and I can do this day, she’d move everything around for me.”

Intrapartum care

All women had received standard care during their labour and birth. Women reported that it would have been nice to receive care from one of their midwifery-led continuity of carer (MCC) midwives at this time. However, they acknowledged that the care they received from hospital midwives during labour was broadly positive.

> “I would have preferred it if it was somebody who I had seen throughout my pregnancy, just for my own piece of mind that she knows how I’m like.”

> “I think it would have been nice if my midwife could have been there, it would have just been obviously completing the journey…the midwives at the hospital were amazing as well.”

Value of the continuity of carer model

All women expressed value and/or appreciation for the care they received in the continuity of carer model.

> “It’s been a lovely experience…it was a different experience with the home visits, which I honestly preferred…it was just a lot nicer.”

> “I received the best care you could ever receive from my midwives.”

Case Study

Mrs Bashir's story

At seven weeks' pregnant, Mrs Bashir attended her first appointment: the 'booking appointment' with Personalised Midwifery Team midwife Steph Marriott. As this was her fourth pregnancy (and based on prior experience) she expected her midwifery care to be a rushed, form filling, non-personal experience. She could not have been more wrong.

Mrs Bashir said: "Before I met Steph, I had always felt rushed and as though they were always thinking about the next person waiting; that I was just a name and a statistic."

"But Steph took the time to listen to me: the form filling was always secondary. In previous pregnancies I did not see the same midwife all of the time so I would constantly have to re-explain any issues and it was impossible to build a trusting relationship. Steph has been with me all the way through this pregnancy."

"I was devastated when my mum passed away during my pregnancy. I was feeling down and Steph really helped. I just felt I could talk to her and she listened. She always asked me how I was feeling and because of the consistency of her care and her approach, I felt very relaxed and was able to talk to her about my feelings. I would not have been able to do that with anyone else."

"Steph knew everything about me so I didn't have to start again explaining my history; we built a really good relationship. She even kept my son occupied at one meeting while a trainee did all the formalities."

"Sometimes I could not make it into clinic and Steph worked around my routine and availability: she was so flexible."

"When I gave birth to Zahra, I was really surprised when Steph visited me in hospital. Even though she was on annual leave, she came to see me in hospital as she had checked on the system and had seen that I had, had my baby. That extra touch. That thought. That meant a lot to me!"

Acknowledgements

Author

Rachel Middleton, Specialist Midwife Development Lead, Better Start Bradford.

With thanks to

Alison Powell, Midwifery Lead OMS, Bradford Teaching Hospitals Foundation Trust.

Bethany Lewis, Continuity Manager, Bradford Teaching Hospitals Foundation Trust.

The dedicated staff who have worked within the Opal Team and Clover Team.

The researchers involved in producing the Better Start Bradford Innovation Hub reports, which have played a pivotal role in shaping this Impact Report. These include Sara Ahern, Laura Bates, Pippa Bird, Sarah Blower, Maria Bryant, Tracey Bywater, Nimarta Dharni, Josie Dickerson, Alison Ellwood, Charlotte Endacott, Holly Essex, Mohammad Hammad, Brian Kelly, Rachael Moss, Rifat Razaq, Noortje Uphoff, Kathryn Willan.

Former and current staff at the Better Start Bradford Innovation Hub.

Former and current Better Start Bradford staff, including Specialist Midwives; Alison Brown, Rachel Middleton, Rachel Wild.

Participants of interviews, focus groups, and surveys whose insights and perspectives have significantly informed this evaluation.

Families, volunteers and the early years workforce and partners who have engaged with the Personalised Midwifery Project and Better Start Bradford, enabling the important work to support the community.

The Better Start Bradford Communications Team and Clair Liddell, Senior Data and Evaluation Officer for editing this report.

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October 2025

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