Why continuity of carer matters in group care: a qualitative analysis of women's experiences of Pregnancy & Parenting Circles in England

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Published in: Midwifery, 2026, 104735, ISSN 0266-6138

https://doi.org/10.1016/j.midw.2026.104735

Abstract

Background

Group Care, here described as Pregnancy and Parenting Circles (PPC), is a holistic model of maternity care characterised by a facilitative and interactive approach. Evidence indicates positive outcomes and experiences for women who participate. Its potential to enhance women's empowerment, health and wellbeing as well as their relationships with healthcare services positions group care as an innovative model warranting further investigation.

Research Questions

This study examined: 1). the extent to which the PPC model adhered to the core values and components of Pregnancy Circles; 2). how fidelity to the model influenced women's experiences of care; and 3) how established mechanisms of effect operated within PPC.

Methods

We draw on UK data from an implementation study of Group Care for the First Thousand Days (GC_1000). Data were generated through observations of group sessions and semi-structured interviews with service providers and users. A UK group care randomised controlled trial, REACH (trial registration no: ISRCTN91977441), provided a framework of 'Core Values and Components' utilised in an abductive analytical approach for examining model fidelity.

Results

Findings highlight 'relational continuity' as a central component of group care. Where core components were implemented with fidelity, relational continuity functioned as a key lever, enabling mechanisms such as enhanced engagement and active participation in health. Lack of fidelity disrupted the model's mechanisms, weakening its positive effects on women's experiences of care.

Conclusion

Relational continuity is critical to operationalising the mechanisms underpinning group care. Attention to model fidelity is essential to optimise women's experiences of group care.

Background

Group Antenatal Care, (GANC), is a holistic model designed to address women's psychosocial as well as healthcare needs by integrating clinical care with interactive learning and peer support using a facilitative and interactive approach. In some contexts, GANC has been extended into the postnatal period (Gresh, et al., 2025). Groups of 6-12 women of similar gestation receive their care in 2-hour sessions instead of short 1:1 clinic appointment. Sessions are facilitated by two facilitators who provide continuity, at least one of whom should be a clinical practitioner (e.g. midwife, health visitor) (McCourt, et al., 2024). Women undertake basic screening for common health issues (including checking their own blood pressure and testing their urine), have a brief private 1:1 health check with the midwife within the group space and spend most of the time in facilitated discussions and activities (Rising, 1998; (McCourt, et al., 2024)

A bespoke GANC model known as Pregnancy Circles (PC) was developed by the Research for Equitable Care and Health (REACH) team for implementation within the NHS as part of a randomised controlled trial. The team drew on ten years of qualitative data to identify 4 'core values' with associated components as essential for fidelity to the model: Relational, Interactive, Personalised and Safe (Wiseman, et al., 2025). A realist review identified 6 potential mechanisms of effect for GANC: active participation in health, health education, satisfaction with care, social support and peer learning, and health professional satisfaction and development, with empowerment emerging as an overarching mechanism (Mehay, et al., 2024).

From 2020-2025, Group Care for the First 1000 days (GC_1000), undertook a multi-national study on the implementation and upscaling of group care. In the GC_1000 programme, of two sites in the UK, one extended the GANC model to include collaborative pre and postnatal care (Pregnancy & Parenting Circles – PPC) (Martens, et al., 2022). In England, the NHS provides comprehensive maternity care through midwives who support women during pregnancy, birth, and early postpartum. Health visitors and nursery nurses also play key roles, offering ongoing health and developmental support to families with children under age 5. This model was novel not only because it extended group care into the postnatal period, but because it required midwives and health visitors to work across professional boundaries which has traditionally been identified as challenging (Aquino, et al., 2016).

Worldwide, research on women's experiences of group care illustrates a range of positive outcomes and experiences (McNeil, et al., 2012; Novick, et al., 2013; Carter, et al., 2016; Byerley & Haas, 2017; Sadiku, et al., 2023). As the model takes wing across the globe, its potential for upscaling and sustainability is pertinent to public health bodies interested in the model's recipe for positive experiences (Sharma et al, 2018).

Group care's propensity to improve women's empowerment, overall health and well-being as well as their relationships with health care institutions, situates the model as an innovative solution, worthy of research investment (World Health Organization, 2016). A systematic review and meta-synthesis of women's experiences of group care demonstrates how the relationships they build with their care providers and each other are a catalyst for learning (Horn et al, 2023). Comparatively little research evidence is available on the impact of group antenatal and postnatal care as an integrated model, our study focused on exploring how PPC was implemented in the UK, and the impact this had on women's experiences of care.

Aims

Through a qualitative analysis of data from an NHS service piloting PPC as part of the GC_1000 study, we aimed to better understand:

1. To what extent did the PPC model adhere to the Pregnancy Circles core values and components?
2. How did fidelity to this model (or lack of it) shape women's experiences of care?
3. How did the mechanisms of effect identified in the literature function within the PPC model?

Methods

Theoretical Framework

The international GC_1000 programme used an interpretive case study design informed by realist evaluation principles to enable researchers to investigate "What works, for whom, in what circumstances and why?" (Martens et al. 2022). The analysis reported here draws on the UK case study focused on the piloting of PPC in one NHS site.

Sampling and Recruitment

PPC was implemented in one NHS site ('Alpha'). A second site ('Beta') implemented PC integrated into a continuity team (see: Martens et al, 2022; Van Damme et al, 2024). In site Alpha, pregnant women were approached at their maternity booking visit and invited to have their care as part of the PPC pilot, with no restrictions based on clinical, obstetric or social conditions. Interpreting services would be offered for any participants who needed this support. The PPC model consisted of five 2-hour antenatal group sessions and three postnatal group sessions (See Table 1). Antenatal sessions

were facilitated by two midwives who provided continuity. A Health Visitor would attend one or two of the antenatal sessions to get to know the women and fulfill their statutory antenatal 'contact'. The first postnatal session would be co-facilitated by both midwives and health visitor, and the last two postnatal sessions by the Health Visitors assisted by Nursery Nurses in their team. The content of sessions was co-designed with the practitioners (Martens et al, 2022).

Table 1: Parenting Circles Schedule

Session No.	S1	S2	S 3	S 4	S5	S6	S7	S8
Care Type	Antenatal Care					Postnatal Care		
Stage	GA 16	GA 24-25	G4 28	GA 31	GA 36	8-9 weeks	11-13 weeks	15-17 weeks
Facilitators	2 MW	2 MW	1 MW 1 HV	2 MW	1 MW 1 HV	1 MW 1 HV	1 HV 1 NN	1 HV 1 NN

GA = Gestational Age, MW = Midwife, HV= Health Visitor, NN = Nursery Nurse

Forty-six participants contented to take part and were allocated to two midwifery teams (under the pseudonyms, Topaz and Jade) who each implemented four PPC groups in collaboration with their corresponding Health Visiting teams. Circles B and C of the Topaz Team and K and L of the Jade Team were randomly selected as a sample for data collection from within a total of 8 circles across the two teams.

Data Collection

Sources of data for this analysis include site steering group meeting notes, observation of group care sessions across the 4 selected Circles, interviews and focus groups with group care facilitators and participants (Table 2).

All participants and facilitators involved were invited to take part in an in-depth interview or postnatal focus group, as they preferred, either in person or over Teams (maximum 60 minutes). These were recorded with consent, and the audio was subsequently transcribed and anonymised.

Data Analysis

An abductive approach was followed utilising the mechanisms of group care identified in Mehay et al's (2024) realist review as a framework for coding the data with respect to experience and mechanisms, but with the intention of adapting the framework in response to the emerging themes. REACH, a randomised controlled trial retrospectively registered on 11 February 2019 (trial registration no: ISRCTN91977441), was a precursor to PPC. Since PPC was based on the Pregnancy Circles model, REACH Core Values and Components (Wiseman, et al., 2025) were used as a reference point to consider the fidelity of the implementation in this setting. In an abductive approach, there is iterative movement between pre-existing theory and analysis grounded in the data. Theory is used to provide a map or compass that can guide the analytical logic while enabling surprises and new insights (Timmermans & Tavory, 2022). Using line-by-line coding in NVivo, the first author conducted a thematic analysis across multiple data sources (See Table 2), identifying in the data where, if at all, the mechanisms were identified and where they were not and any additional mechanisms not

identified in the previous literature. All co-authors reviewed and discussed the themes, making clarifications to findings where needed. Whilst not formally analysed, the meeting notes were used to understand the implementation context for our findings.

Ethics

Potential participants received a Participant Information Sheet, as well as a verbal explanation of the study. They had at least 24h to ask questions. Before data collection, a consent form was signed, and participants were made aware that they had the right to withdraw from the study at any point until the analysis was conducted and that their choice would not interfere with the quality of care. Collected data were digitised and securely stored on a university server. The site and team names have been replaced with pseudonyms to protect the identities of participants. Approval was granted (IRAS ID 292310; Rec reference 21/PR/1234) by Bromley NHS Ethics Committee, and funding provided by European Union's Horizon 2020 research and innovation programme under grant agreement No 848147.

Researchers' Characteristics

Authors one and two undertook the data collection, mindful of their positionality as an anthropologist and a registered midwife respectively. The rest of the research team represent a wide range of experience in maternal health, social sciences and health services research, including clinical practitioners in midwifery and health visiting with experience of delivering group care.

Findings

Observations were carried out between November 2022-July 2023, and interviews/focus groups between May 2023-February 2024 (presented by PPC in Table 2).

Table 2: Summary of Data Collection from Sept 2022 to Sept 2023

PPC	Sessions	Participant	Observations	Participants' IDI/FG	Facilitators' IDI/FG
Jade K	8	9	2	1 FG with 4 participants in May/23	4 IDIs (2 midwives, 2 health visitors) 1 FG (2 midwives)
Jade L	8	7	3		
Topaz B	8	5	4	2 FG with 3 participants on 4th/July	
Topaz C	8	6	2	5 individual interviews conducted in Feb-May/23	
TOTAL	**32**	**27**	**11**	**5 IDIs, 3 FGs**	**4 IDIs, 1 FG**

Fidelity of care

We found different levels of fidelity to the core Values & Components in each team; in particular, 'relational continuity', 'engagement and satisfaction' and 'active participation in health', as outlined in Table 3. 'Yes' was allocated if data was interpreted to be associated and 'No' was allocated if the component was not found within the data. 'Not available' signifies that there were no clear data available in relation component. Fidelity findings are discussed in more detail below.

Table 3: Summary analysis of core values and components by team based on the REACH Pregnancy Programme's Pregnancy and Parenting Core Values Model, (Wiseman et al. 2025)

	Topaz	Jade	
Relational Continuity			
Continuity of care from named midwives/healthcare providers	No	Yes	Disparities in the application of continuity of carer between the two teams, most notably amongst the health visiting arm of care during the postnatal phase of Parenting Circles on the Topaz Team.
Continuity of peers in each Pregnancy Circle building social networks	Yes	Yes	The cohorts of service users were the same throughout the course of care.
Inclusive of all women and fostering group cohesion	Yes	Yes	All women were invited to attend, regardless of parity or obstetric needs.
Support in the postnatal period	Yes	Yes	All women received care during the postnatal period.
Continuity of language support when needed	Yes	Yes	Women who required interpretation services were matched with an interpreter who attend the group sessions.
Relationships and community building			
Midwives/midwives and health visitors working together to provide care	No	Yes	Disjointed session planning resulted in a 'turn-taking approach' within the group sessions rather than collaborative and cohesive facilitation between midwives and health visitors in the Topaz team.
Developing staff facilitation skills	No	Yes	Some facilitators were didactive in their delivery on the Topaz team. Facilitators on the Jade team displayed a higher level of skill and application in facilitative care.
Linking midwives, student midwives, health visitors and other providers	Yes	Yes	The model provided opportunities for both intra- and inter- professional contact and collaboration.
Community-based settings with a focus on pregnancy as a part of the life course	Yes	Yes	Both groups were held in community settings.
Support from peers to foster social support and strong communities	Yes	Yes	Women under both care teams described the value of providing and receiving peer support from other group members.
Personalised and interactive			
Time to enable holistic care, including mental health and wellbeing	Yes	Yes	Both groups were allocated 2-hours antenatal and 1-hour postnatal sessions, providing them with participants with more contact time with health care workers and peers.

Women-led and interactive discussions to ensure responsive care	No	Yes	More discussions were observed in sessions from the Jade team where care was more facilitative than in the Topaz team, where discussion often became professionally-led, rather than facilitated, and didactic.
Women encouraged to understand and conduct self-checks	Yes	Yes	Women were observed carrying out their self-checks and displayed an understanding of the results.
Emphasis on choice, supported decision-making, and empowerment	Partially	Yes	Choice and decision-making were particularly a part of conversations around birth options. Conversations about choice and decision-making were less often observed during postnatal sessions in the Topz team, where facilitators were more didactic.
Brief one-to-one time with a midwife	Yes	Yes	Both teams incorporated brief 1:1 clinical check with the midwife during the sessions.
Support for additional language needs (e.g. interpreting services)	Yes	Yes	Where applicable women were allocated an interpreter for the duration of group care sessions.
Holistic Safety			
National standards of care followed	Yes	Yes	Both midwifery and health visiting professionals across both teams maintained national standards of care.
Wrap-around model combining healthcare, education and social support led by two facilitators, at least one of whom is a healthcare professional	Yes	Yes	Both teams provided a combination of healthcare and education where women were able to offer social support to one another. At each session at least one or more facilitators were certified health care professionals.
Psychosocial, cultural and physiological safety	Not available	Not available	Women reported positive mental health, particularly as a result from peer support and were provided with care in line with professional standards. However, direct measures to account for cultural and psychosocial safety were not a part of the investigation.
Increasing access to and responsiveness of health services	No	Yes	Women from the Topaz team reported disruption in communication with health services.
Building health knowledge and self-efficacy	Partial	Yes	Women from groups described gains in health knowledge from self-checks and shared information from peers. However, women from the Topaz team described the group topics as repetitive.

This summary highlights the impact of a range of implementation challenges which affected the delivery of the models. First, COVID-19 pandemic recovery plus midwifery and health visitor staffing shortages delayed the start of recruitment and affected capacity to explain the care. Participant numbers were therefore lower than expected, resulting in smaller Circles than planned (average of 4.3 in Topaz team and 7.3 in Jade team rather than 6-12 per group as planned). The smaller Circles created facilitator: participant ratio imbalances in some sessions with too many staff members compared to number of women in the group. Delays also meant that some professionals had up to a year's hiatus after attending the training workshop before beginning to facilitate or had not received training at all. Some of those rostered had not volunteered for the pilot, which may have reflected delays plus lack of middle-manager active involvement in the project leading to lack of understanding of the model's working and requirements such as facilitation training and continuity. This was reflected in practitioners' reported lack of confidence and facilitation skills. For example, researcher field notes revealed that some of the midwives on the Topaz team sat on tables in the outer circle of the group, positioning themselves apart and above the women rather than within the circle, as practised in the training workshops.

Sourcing and financing appropriate venues were also a key challenge, and the Topaz team having to move to a new venue half-way through which was much further to travel for women attending the groups.

Mechanisms of Care

In the analysis of mechanisms, we identified 'relational continuity' as a central component of the model, acting as a lever to operationalise mechanisms, in particular 'engagement and satisfaction' and 'active participation in health' (Wiseman, et al., 2025). Further, we illustrate how the lack of relational continuity in some circles affected women's experiences of care.

Relational Continuity

In the Jade team, where groups maintained the same facilitators, rich relationship-building techniques were observed. For example, one health visitor felt comfortable to share her personal experience of postnatal depression which motivated participants in the group to share their own mental health experiences. This kind of personal exchange encouraged relationship development amongst service users and facilitators, creating opportunities to build trust, increasing disclosure which allowed for personalised care planning.

"...we had a mum disclose that she was struggling with her mental health, and she was quite tearful. She asked me what my role would be in supporting her...I'm quite open about my mental health and I had postnatal depression myself. I said to her that [I am a health visitor because] I was a mother suffering from postnatal depression... I'm going to see her at the six-to-eight week [postnatal check]... [I believe] she is going to be much more relaxed because she has met me already, but none of it would [have been picked up] if she did not talk about her mental health. HV1/Jade

The analysis revealed that continuity of carer is pivotal in the group care model, underpinning the development of meaningful relationships with service users. Such moments were not observed in PPC sessions. Service users in one Topaz Circle recalled a session where a health visitor appeared to be underprepared for group discussions. One woman stated,

"They were told like five minutes before they were going to come in that they were going to talk to these women… and they were like 'uhh...sorry. I don't know what I'm doing'. W4/Topaz

Lack of relational continuity stifled not only the relationship development between the group and the facilitator, but also impaired the flow of discussions, as facilitators were not aware of what had been discussed, what was planned to be discussed and what the women found to be important. One male partner who attended most group care sessions said,

"...there was just no structure... and [the facilitators] would come and go… It was obvious they were trying to fill the gap, longing out the two-hour slot." - Male Partner/Topaz

Women under the care of the Topaz team made disparaging comments about the sessions where there was a disruption to continuity, resulting in issues raised by women not being followed up:

"I asked at the start if we would be [learning about first aid], she said that she didn't know and then they never really did it. That would have been really helpful…" W2/Topaz

While continuity provided opportunity for building trust and personalised care planning, disruptions in continuity observed in Topaz resulted in disorganised care delivery which affected service users'

perception of the sessions. For example, in instances where staff attended a single session or were unfamiliar with the programme.

Engagement and Satisfaction

In some groups, most notably from the Topaz team, where continuity of carer was disrupted and facilitation skills were at times unrefined, women expressed some dissatisfaction with the facilitative aspects of their care; and although they regularly attended sessions, this did not necessarily fully equate to high engagement with staff. A few of the women in one Circle described disinterest in the sessions due to repetitive topics and uninteresting activities. In observations, these sessions were also seen to be more didactic in nature and women stated that facilitators seemed 'patronising' for revisiting the same subject. Lack of continuity affected communication and follow-up by facilitators, including about clinical issues s (e.g. blood results).

However, it was notable that even where women were relatively unengaged and dissatisfied with their care providers, they still benefitted from the peer support and relationships with other pregnant women. As one woman said:

"I would do [group care] again to meet people, but that would be the only reason I would do it." W3/Topaz

Active Participation in Health

Active participation in health includes not only the self-checks performed by women but also active discussions and problem solving amongst the group participants. The woman's self-check within the model was a feature widely implemented across both teams in Site Alpha. The group care providers felt self-checks improved health literacy, and this was supported by participants. For example, a woman from the Topaz team said, *"I felt like I knew more about my blood pressure. It wasn't just someone taking a random measurement…I could but understand [it]… That made me feel a bit more connected to my body when I was pregnant. And I wanted to know how things were afterwards." W1/Topaz*

Observations suggested that partners also benefitted from the interactive nature of the self-checks in the model as it offered opportunities for them to learn about health in pregnancy.

Women and their partners enter the room. Self-checks and one-to-one checks with the midwives start immediately. A woman sits with her male partner to do a blood pressure check. They look at the blood pressure chart on the wall. After the woman measures her blood pressure, the partner turns to her and says, "That's a high blood pressure reading." Author1/Obs2/Topaz/Circle C

Observers noted that in the Topaz Circles facilitators spent more time talking than in Jade Circles, where women's voices were facilitated. Topaz Team accounted for most of the didactic sessions observed, and researchers reflected upon this finding in their field notes:

I got the sense that the facilitators did most of the talking during this session. The health visitor, particularly, mostly asked 'yes' or 'no' questions to the group, rather than open-ended questions to

allow women to take part and lead the discussion. Interestingly, the health visitor announced what the group would be discussing which, to me, didn't leave much room for emergent discussions from the women or their partners. I am not sure if the health visitor had training in delivering group care, but it felt more like a one-to-one appointment held in a group setting where the health visitor, particularly, asked 'if there were any more questions' after she'd finished talking, to which women responded that they had none. Author1/Obs2/Topaz/Circle C

[It] felt like women were receiving a lot of information from midwives (who were sitting on tables in front of the Circle rather than with the women). Author2/Obs1/Topaz/Circle B

Interactive discussion is an avenue for participating in healthcare, allowing women contribute and share their experiences. Where this happened, questions and solutions appeared to be more personalised and produced further resources and peer support. For example, an instance of a dynamic discussion was observed in the Topaz team where both women and the facilitator co-produced a conversation, each contributing to the point.

Woman 1 shares her experience about incontinence after birth and says she is worried it's going to happen again. Midwife 2 asks if she has already seen a physiotherapist about her pelvic floor health. Woman 1 says no.
Midwife 2 offered to book her an appointment for a physiotherapy session to talk about pelvic floor exercises.
Woman 3 says she attended a session when she was around 20 weeks pregnant. She says that she is now using an app to remind herself to do her pelvic floor exercises.
Midwife 1 and Midwife 2 discuss the importance of building the habit of maintaining pelvic floor muscles now so it's easier in the future.
Woman 4 reassures the other women that she managed to regain pelvic floor muscles strength after the birth of her first baby.

This moment revealed how active discussion plays a role in connecting women with resources, in this case an app for pelvic floor exercises, however most observation notes of Topaz documented that facilitators often fell back into a didactic communication style. When this happened, active and interactive learning diminished. With a one-way stream of communication, the nonverbal cues which signal to others in the group to contribute are blurred. Potentially stifling opportunities to posing questions to the group and collaborating with one another to reach an answer. This resulted in the learning component of the model becoming less interactive, relying mostly on what the facilitator felt to be important to discuss.

This example from Jade team illustrates how responding to participant cues and posing open questions to the group supports rich discussions:

ML tells the women about upcoming features of upcoming appointments: blood tests at 28 weeks and 34 weeks.
W4: I've just been diagnosed with gestational diabetes.
ML (addresses the group): What do we think of diabetes?
W4: They told me about my diet. I am still waiting for my test kit.
AX: (the researcher/observer): I had gestational diabetes in my last pregnancy.
W1: Do you have it in every pregnancy?
AX: I didn't have it with my daughter, but I did have it with my son.
W4: How did you find it?

AX: It was a challenge at first, but I got into the swing of it. My advice – give yourself a few weeks to get the hang of the diet. Gestational Diabetes UK (a Facebook group) was a good resource. I learned how to pair my food and I walked twice a day, after lunch and dinner, to lower blood sugars.

We found that both engagement and satisfaction with care, and active participation in health were important mechanisms in PPC but these relied on continuity of carer. Continuity across the antenatal and postnatal period, as seen in Jade team, enriched the interactivity and the support women received.

Discussion

Our research illustrates how continuity of carer affects staff's ability to take a facilitative approach to group care as well as impact on social support and informational continuity. Challenges in implementation can alter the fidelity of the model, negatively influence the experiences of service users and unsettle the mechanisms of effect in two key areas: 'engagement and satisfaction' and 'active participation in health'. An immediate determinant of women's learning and investment in relationships with their provider in the group care context often comes down to the art and skill of facilitation as well being able to get to know the participants and plan sessions coherently. Evidence from this analysis reveals that embedded within continuity of carer is the potential to co-create an atmosphere which makes the care 'relational', a component integral to a trusting and therapeutic partnership. Other research on continuity of care also reveals the impact of relational continuity (Dahlberg & Aune, 2013). Conversely, lack of continuity limits the ability of providers to develop and consolidate skills group facilitation which are typically underdeveloped in professional education and socialisation (Hunter, et al., 2018).

Staffing shortages, particularly severe in the health visiting teams, contributed to lack of continuity and were compounded by the need for initial group care training so that the pool from which facilitators were selected to cover sessions was limited. With the Jade team, one health visitor was able to cover most of the sessions. Consistency of contact with the group supported familiarisation with both the model and the participants, which improved the facilitator's confidence and facilitation and communication skills and the inter-professional collaboration to support this. When continuity of carer was present, a deeper understanding of relationship building techniques was observed and reflected in facilitator and participant interviews. This contrasted with the Topaz team, who were more vulnerable to disruption of continuity, and inexperienced and less confident facilitators sometimes reverted to didactic, one-directional antenatal education teaching techniques which reduced engagement and perceived learning. Dialogic practice (Freire, 1996) is a pedagogical method which utilises the power of conversation to stimulate thinking and has been found to be a more effective learning tool than didactic teaching in groups (Cohen, 2018). The self-checks and group setting made opportunities for active participation more possible. Equally, the interaction with other women positively influenced care engagement and satisfaction. However, continuity and more relational care could have enabled more active discussions, particularly for women under the care of the Topaz team.

Other contributing factors to the disparity in experiences between women under care of the two teams included lack of a suitable venue space and group size. The use of 'the circle' formation in group care is no accident. The shape symbolises and evokes dialogue, unity and egalitarianism (Baldwin & Linnea, 2010). Cost and venue availability was a challenge that disproportionately affected the Topaz team, forcing Circles to change locations and make use of a venue that was too

small to fit women and their partners comfortably. As a result, facilitators took positions outside of the circle and our study found that this unsettled the function of being seated in a circle which could stimulate conversation and challenge power dynamics. The challenges experienced in identifying and gaining access to community-based venues suitable for a group approach reflects structural features of care which, despite policy recommendations, remain institutionally focused (McCourt, et al., 2024). Group size for both teams (but especially Topaz) were smaller than expected. Smaller group sizes created a challenge to stimulate dynamic group discussions and as a result some facilitators reverted to didactic speaking to progress the group care session.

Health Visitors and midwives were not given protected time to plan sessions together which, along with poor continuity, resulted in the overlap and repetitiveness in group topics observed in the Topaz team. Limited continuity of facilitators in Topaz may have contributed to lower engagement, satisfaction and active participation in health among the participants, who kept seeing new facilitators. Lack of continuity also limited practitioner's ability to build their facilitation skills and confidence in managing groups, falling back on more didactic delivery of information.

Delays in facilitator training meant that some professionals had up to a year's hiatus from the training workshop before applying their new skills in practice. Middle managers play a crucial role in communicating the aims of a model across the team and making plans for continuity and training resources. Some staff rostered had not volunteered for the pilot or received training at all which may have reflected the gaps in their knowledge of the model. Lack of active involvement from middle managers in the project may have compounded the lack of understanding across the team as well as facilitation training and continuity.

In addition to adequate preparation through planning schedules, group facilitation workshops and mentoring, continuity also had a key role in enabling professionals to develop and consolidate their skills. Future implementation plans should carefully consider the art and skill of facilitation and how it is tethered to continuity of carer, as well as the service features that help or hinder the ability to implement group care with fidelity to its core values and components (Wiseman, et al., 2025). Recent training for group care facilitators supports effective implementation of the PPC model. Service commissioners and providers should consider how overall service design, structure and organisation can affect the capacity to provide care that is community and relationally based, with interprofessional collaboration and centred on people and their communities. More research is needed to understand the soft skills essential to executing the model effectively and the ways in which those skills yield positive biopsychosocial outcomes including women's empowerment, cultural safety and improved pathways to physiological birth.

Strengths and Limitations

This was a small-scale study of the first implementation of an integrated group care model in maternity care in the UK. This analysis explores women's experiences with a new group model of antenatal and postnatal care in England that integrates midwifery and health-visiting services, providing further insights into the group model's underpinning mechanisms. A strength of the study was the mix of qualitative methods and perspectives, including researcher observations, provider and participant interviews or focus groups. However, as the study examines the early stages of implementing a new care model, the circumstances under evaluation were novel for staff, with providers navigating an unfamiliar approach rather than operating within an established framework. To acknowledge these limitations, the challenges observed in facilitation skills and continuity may

reflect the model's early implementation phase and may not be present if it were a mature, well-established practice.

Conclusions

This study identified variations in the fidelity of implementation between two teams piloting PPC in a specific NHS service in England, in particular affecting Topaz's ability to provide continuity of facilitators (both midwives and health visitors) in their Circles. Continuity of carer is an important component of group care, and we found that disruption to this pillar strains its mechanisms, affecting how the model is delivered and experienced. This research demonstrated that group facilitation may be ineffective when staff lack training or were trained long ago since maternity professionals are unfamiliar with group facilitation and co-working. Insights gained from women's experiences suggest that disruptions to continuity in group care negatively affect the development of professionals' skills and their care experience.

Table 4: Acronyms

FGD	Focus Group Discussion
GA	Gestational Age
GANC	Group Antenatal Care
HV	Health Visitor
IDI	Individual interview
MW	Midwife
NHS	National Health Service
NN	Nursery Nurse
PPC	Pregnancy & Parenting Circles
REACH	Research for Equitable Antenatal Care and Health

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