Anti-Racism QI Change Package: Perinatal Mental Health

Race and Health Observatory Learning and Action Network

The NHS Race & Health Observatory (RHO) has partnered with the Institute for Healthcare Improvement (IHI) and the Health Foundation (HF) to deliver a Learning and Action Network (LAN) which aims to tackle the gaps in maternal and neonatal morbidity, between women and babies from different ethnic backgrounds.

The LAN has used Quality Improvement (QI) to drive clinical transformation and enable system-wide change. NHS RHO, IHI and an Advisory Group made up of experts in maternal and neonatal health have joined together to improve the outcomes for maternal and neonatal health through participation in an action oriented, fast-paced LAN.

The LAN is comprised of ten teams, from eight Integrated Care Systems (ICS), in four regions who are committed to reducing pregnancy complications and preventable morbidity and mortality for ethnic minority communities.

Institute for Healthcare Improvement

For 30 years, the Institute for Healthcare Improvement (IHI) has used improvement science to advance and sustain better outcomes in health and health systems across the world. We bring awareness of safety and quality to millions, accelerate learning and the systematic improvement of care, develop solutions to previously intractable challenges, and mobilise health systems, communities, regions, and nations to reduce harm and deaths. We work in collaboration with the growing IHI community to spark bold, inventive ways to improve the health of individuals and populations. We generate optimism, harvest fresh ideas, and support anyone, anywhere who wants to profoundly change health and health care for the better. Learn more at ihi.org.

Contents

Key Terms and Definitions

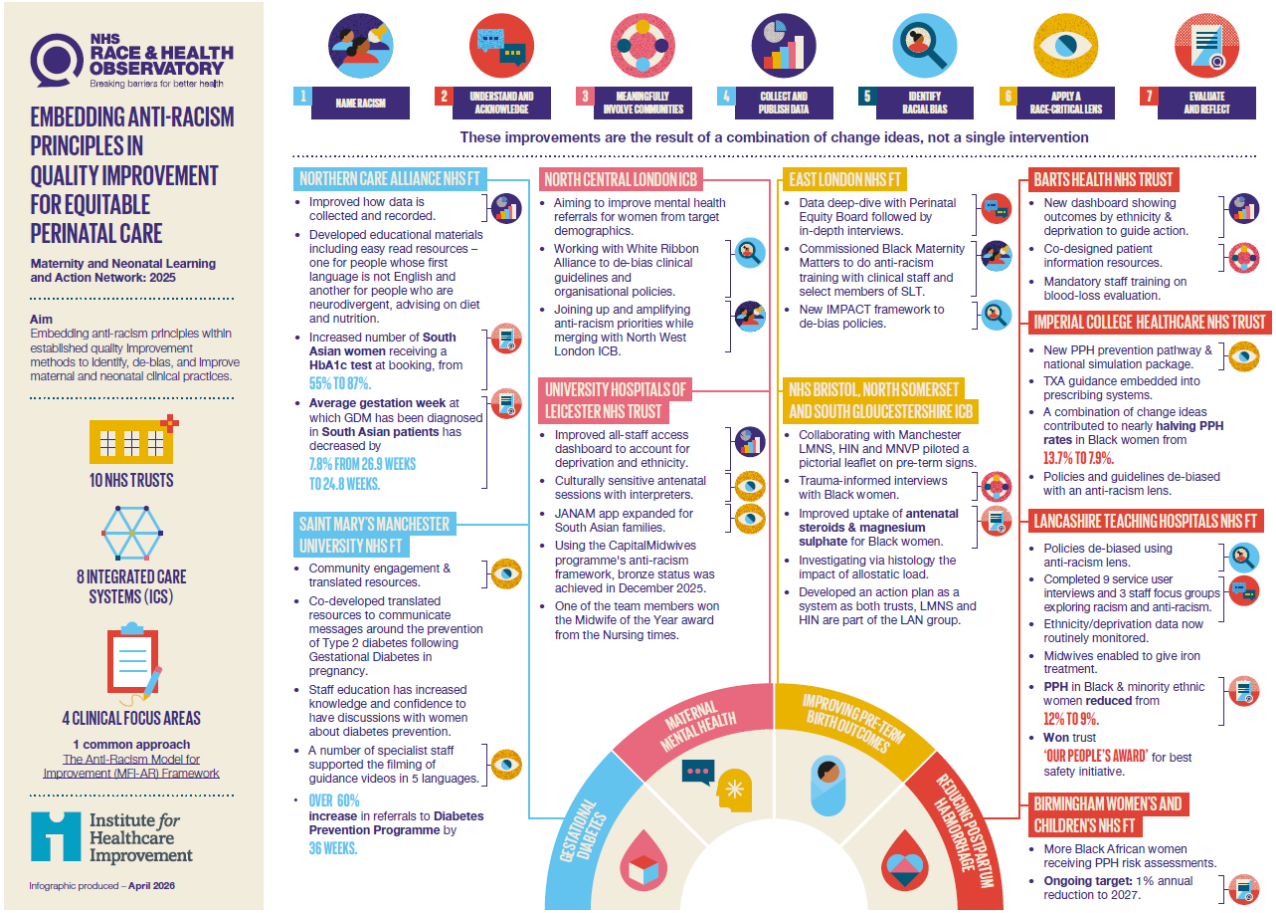
To support understanding, this glossary highlights key terms used throughout this change package. It includes clinical, quality improvement, data and health inequalities terms that may be unfamiliar to some readers.

Term	Definition
Change Concept	A general notion or approach to change that has been found to be useful in developing specific ideas for quality improvement
Change Idea	Specific actions that can be tested to see if they lead to improvements in processes or outcomes
Disaggregated Data	Data broken down into smaller groups, such as race, ethnicity, language, or deprivation, to identify differences in outcomes and experiences
Ethnicity	A socially constructed category reflecting shared cultural markers, including language, religion, heritage, and identity, that people use to describe belonging. In practice, ethnicity captures lived cultural experience and can shape health behaviours, access, and interactions with services
Equality	The right of different groups of people to have a similar social position and receive the same treatment
Equity	The quality of being fair and just, especially in a way that takes account of and seeks to address existing inequalities

Institutional Racism	Policies, processes, and practices within organisations that, intentionally or unintentionally, create or maintain racial inequities
Internalised Racism	The acceptance or internalisation of negative racial stereotypes, beliefs, or messages by individuals from racially minoritised groups, which can influence self-worth, expectations, behaviours, and wellbeing
Interpersonal Racism	Racism that occurs between individuals, including discrimination, prejudice, stereotyping, bullying and harassment
Race	A socially constructed system which categorises people based on perceived physical traits (e.g., skin colour), historically produced and maintained through power structures including colonialism. The term does not have a genetic basis and varies significantly, geographically and temporally. In UK health systems, race is best understood as a proxy for exposure to racism, rather than a biological determinant
Stratified Data	The organisation of data into distinct subgroups or layers (strata) based on shared characteristics to enhance analysis and reveal patterns
Structural Racism	The ways in which racism is embedded within social, economic, political, and cultural systems, resulting in unequal access to resources, opportunities, and health outcomes for different racial and ethnic groups

Learning Action Network: Impact and Achievements

This infographic provides an overview of the achievements of the RHO Maternal and Neonatal LAN. It illustrates how the ten LAN teams embedded the RHO's 7 Anti-Racism Principles within the Model For Improvement methodology to improve equity in perinatal care. The recommendations and resources contained within this Change Package draw on the learning generated through this work. Change Packages for the additional focus areas are available on the RHO website.



Perinatal Mental Health Change Package

Introduction & How to Use This Guide

This Anti-Racism QI Change Package is aimed at supporting teams and institutions close the maternal and neonatal health outcomes equity gap caused by racism. It is based on the learnings of the RHO LAN, a 15-month initiative from January 2024 through March 2025 with the aim to:

Reduce clinically avoidable severe perinatal morbidity and mortality resulting from racism, while improving care experiences for women and people from Black, Asian, and minoritised ethnic communities.

The NHS RHO defines racism in health as the process by which members of a racial or ethnic group have unequal access to services and resources, differential experiences within the healthcare system, and diverging health outcomes when compared with the White majority group. As such, racism harms individuals and undermines the full potential of the whole of society.

As a guide for future teams, this change package contains five elements, framed around the Model for Improvement and centred on equity and anti-racism:

I. **Aim**: What are we trying to accomplish?
II. **Driver Diagram**: How will we reach our aim?
III. **Change Concepts and Ideas**: What changes can we make to reach our aim?
IV. **Prioritising Changes**: Where do we start?
V. **Measurement Guidance**: How will we know if a change is an improvement?

For more information regarding the Model for Improvement: Anti-Racism Framework Guidance, please visit: https://nhsrho.org/resources/mfi-ar-framework-guidance/

What Is an Anti-Racism QI Change Package?

An Anti-Racism QI Change Package is a change package that centres the RHO's 7 Anti-Racism Principles in Action, combining these principles with the Model for Improvement's QI methodology to help a team and system reach its aim of closing the equity gap in health outcomes and experience.

This Anti-Racism QI Change Package is structured around the five key pillars that encompass the main "drivers" or levers for improvement:

1) Leadership at all levels committed to creating an anti-racist system
2) Integration of anti-racism approaches in improvement efforts
3) Reliable delivery of debiased clinical guidelines and protocols
4) Close the equity gap in experience of care of service users
5) Stratified data across race and ethnicity for improvement

This change package has been revised since the completion of the 15-month LAN, in order to include and highlight the change packages with the highest confidence for improvement towards the aim, as well as including considerations for spread and scale.

In this change package, we outline a set of change concepts and ideas aligned with the five key pillars above. We also encourage you to develop your own change ideas based on your unique system and the "causes of the causes" of inequitable maternal and neonatal health outcomes. By this, we mean the social determinants of health, factors such as housing, income, education, and employment, which, as highlighted in *Build Back Fairer*, are themselves shaped by structural forces including racism. These upstream drivers create the conditions in which inequities arise, and many of them are in your team's gift to affect.

Context and Aim

Evidence points to a widening gap in maternal mortality and morbidity between women from different ethnic backgrounds, with Black British mothers up to four times more likely than White mothers to die during pregnancy or within the first six weeks after childbirth.

While there have been numerous NHS initiatives focused on maternal health to date, there has been an opportunity to focus specifically on closing the widening ethnic inequality gap in mortality and morbidity in the NHS.

This LAN aimed to tackle the gap in ethnic inequality by using QI methodology to drive clinical transformation and enable system-wide change.

With representatives from eight ICS's across four NHS regions, who are committed to reducing pregnancy complications and preventable morbidity and mortality for ethnic minority communities, the original aim of this 15-month LAN was to:

Reduce clinically avoidable severe maternal morbidity, perinatal mortality and neonatal morbidity while improving experience of care of pregnant women and people from Black, Asian and minority ethnic groups.

Centred on the RHO's 7 Anti-Racism Principles, beginning with #1: Demonstrate leadership by naming racism, the aim of the LAN has been revised to name racism more explicitly:

Reduce clinically avoidable severe perinatal morbidity and mortality resulting from racism, while improving care experiences for women and people from Black, Asian, and minoritised ethnic communities.

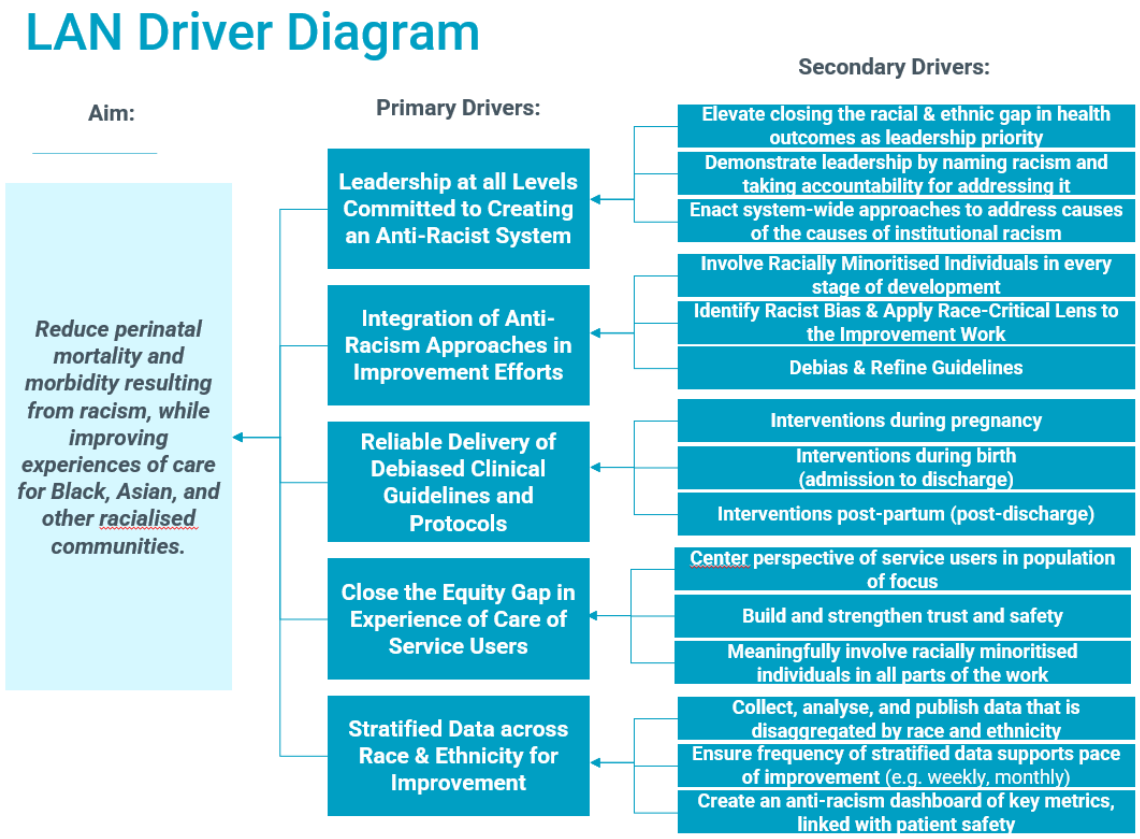
Driver Diagram

While the LAN's original driver diagram focused on three pillars (Reliable delivery of clinical guidelines and protocols, 7 Anti-Racism Principles in action, and Experience of care), feedback from participants of the LAN pointed to the criticality of leadership at all levels committed to anti-racism work and creating an enabling environment for true change. Similarly, challenges around data and measurement highlighted the need to explicitly add stratified data as a primary

driver. Similar to the revised aim above, this final Driver Diagram also names racism more explicitly, taking action on the RHO's first Anti-Racism Principle of naming racism.

Centred on the RHO's 7 Anti-Racism Principles and putting these into action through QI methodology, the five primary drivers were revised to:

1) Leadership at all levels committed to creating an anti-racist system
2) Integration of anti-racism approaches in improvement efforts
3) Reliable delivery of debiased clinical guidelines and protocols
4) Close the equity gap in experience of care of service users
5) Stratified data across race and ethnicity for improvement



Clinical Areas of Focus

As a LAN, the guiding principle was "inch wide, mile deep" to accelerate learning and improvement towards reducing ethnic and racial inequities of maternal and neonatal outcomes. In other words, what were the specific narrow clinical areas we could focus this initial phase on, with the intent of better understanding and acting on racism as a driver of inequitable maternal and neonatal health outcomes?

Based on evidence from the MBRACE-UK report, team applications, and looking across the continuum of prenatal, perinatal, and postnatal maternal and neonatal care, the following four clinical areas of focused were prioritised for this initial LAN:

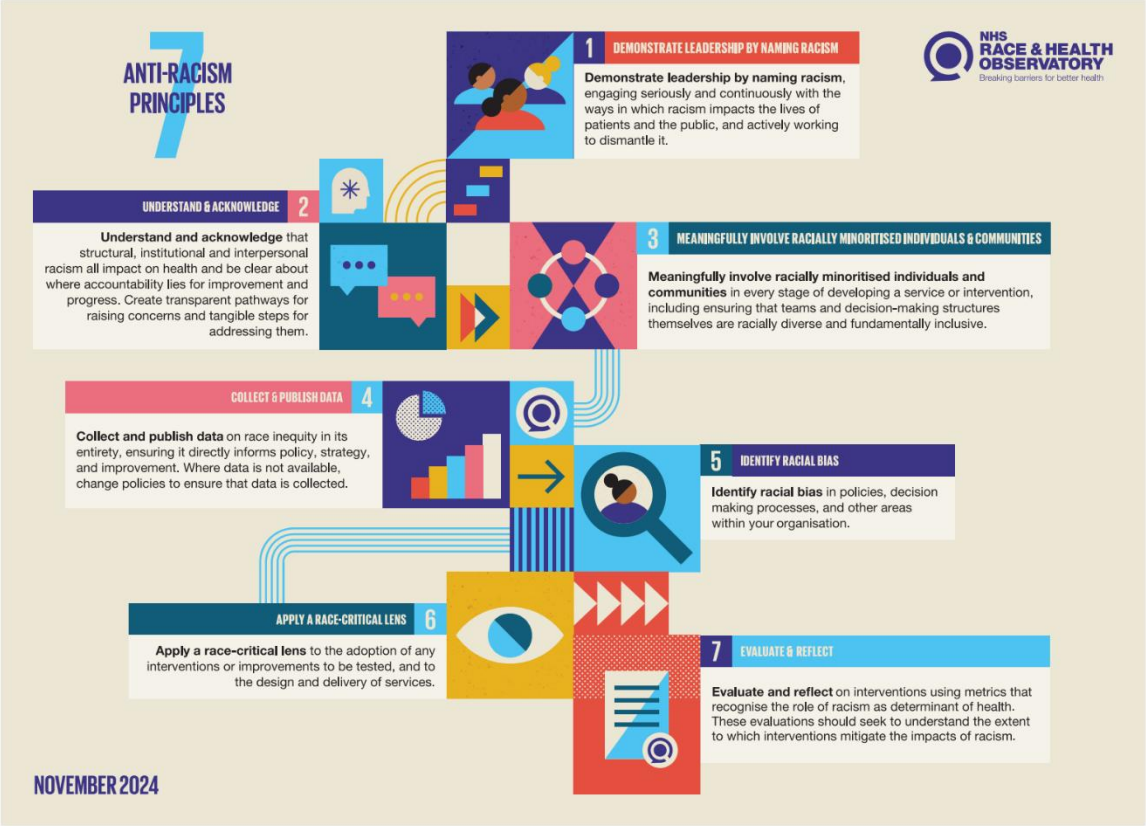
(1) Gestational Diabetes
(2) Haemorrhage
(3) Maternal Mental Health
(4) Preterm Births

Each participating LAN team chose one initial clinical focus area to begin with.

RHO 7 Anti-Racism Principles

Embedded in this work and cutting across all clinical areas of focus above are the following 7 Anti-Racism Principles, developed by the Race and Health Observatory:

1. **Demonstrate leadership by naming racism**, engaging seriously and continuously with the ways in which racism impacts the lives of patients and the public, and actively working to dismantle it.
2. **Understand and acknowledge** that structural, institutional and interpersonal racism all impact on health and be clear about where accountability lies for improvement and progress. Create transparent pathways for raising concerns and tangible steps for addressing them.
3. **Meaningfully involve racially minoritised individuals and communities** in every stage of developing a service or intervention, including ensuring that teams and decision-making structures themselves are racially diverse and fundamentally inclusive.
4. **Collect and public data** on race inequity in its entirety, ensuring it directly informs policy, strategy, and improvement. Where data is not available, change policies to ensure that data is collected.
5. **Identify racial bias** in policies, decision making processes, and other areas within your organisation.
6. **Apply a race-critical lens** to the adoption of any interventions or improvements to be tested, and to the design and delivery of services.
7. **Evaluate and reflect** on interventions using metrics that recognise the role of racism as determinant of health. These evaluations should seek to understand the extent to which interventions mitigate the impacts of racism.



Anti-Racism Change Package for Perinatal Mental Health

1. Aim: What Are We Trying to Accomplish?

Setting a clear project aim is the foundation of any quality improvement project. To be effective, aims should be SMART: Specific, Measurable, Achievable, Relevant, and Time-bound. Within the clinical focus area of perinatal mental health, our aim is to:

Increase # of women from Black, Asian, and minority ethnic communities who access perinatal mental health services.

The ultimate vision for this work within perinatal mental health is to:

(1) Close the racism-related gap in health outcomes in perinatal mental health; and
(2) Close the racism-related gap in experiences for mothers experiencing perinatal mental health conditions.

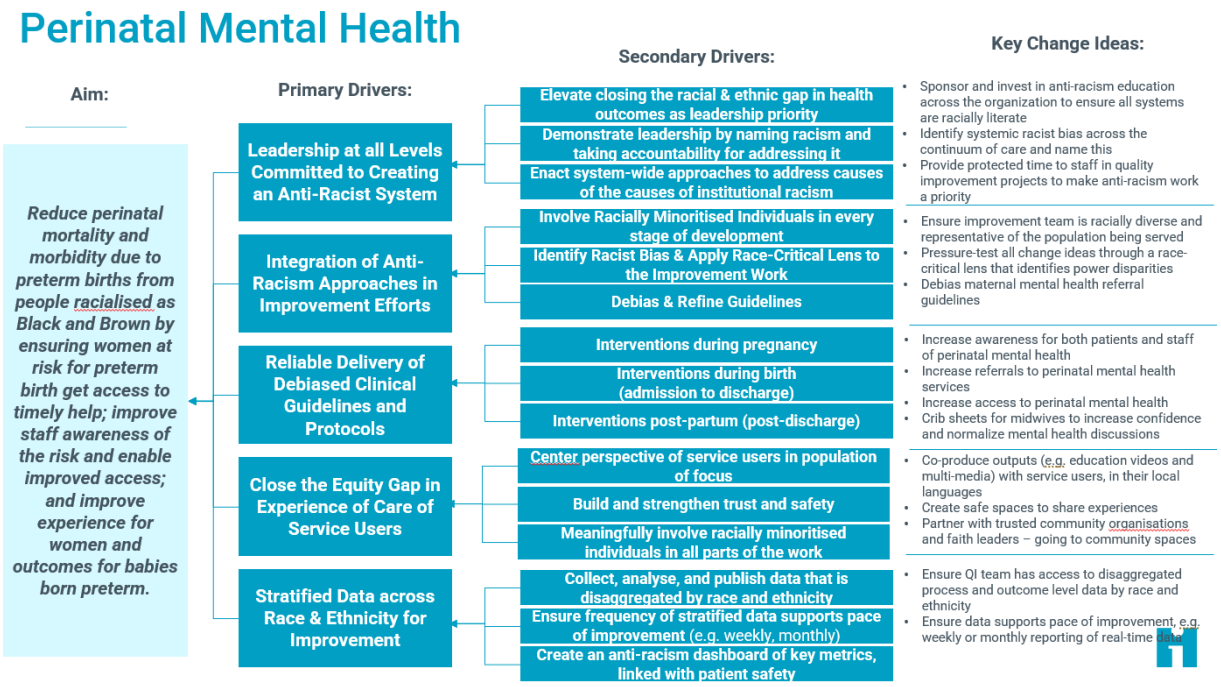
Note: Using the “inch wide, mile deep” approach, future teams will want to focus their work on a narrow area of improvement, depending on where local data points to as the highest potential area for improvement. For instance, LAN teams focused on maternal mental health had the following aims for the 15-month LAN:

***East London Foundation Trust's Aim**: Increase access for Black African, Black Caribbean and Mixed White/Black African and Caribbean women to ELFT Perinatal Services by 10% by March 2025.*

***North Central London's Aim**: Increase referrals to perinatal mental health services by 15% amongst Black women and pregnant people in the N15 and N17 postcodes*

***University Hospitals of Leicester's Aim**: Increase referrals of South Asian women and birthing people in Leicester City to antenatal perinatal mental health services by 20%.*

2. Driver Diagram: How Will We Reach Our Aim?



3. Change Concepts and Ideas

The tables below outline prioritised change concepts and example change ideas across the five primary drivers of:

A. Leadership at all levels committed to creating an anti-racist system
B. Integration of anti-racism approaches in improvement efforts
C. Reliable delivery of debiased clinical guidelines and protocols
D. Close the equity gap in experience of care of service users
E. Stratified data across race and ethnicity for improvement

A. Leadership at All Levels Committed to Creating an Anti-Racist System

Leadership commitment to anti-racism at all levels is the first primary driver because sustained improvement in this area is not possible without leadership commitment. In order for the rest of the drivers to lead towards improvement, the system must be primed and ready – for instance,

through anti-racism education that builds racial literacy and ensures anti-racism work is integrated with QI work from the outset. Otherwise, there is a risk of harm when individuals and teams embark on equity QI work if the system is not ready for this type of work.

	Secondary Driver	Change Ideas
A1	Elevate closing the racial & ethnic gap in health outcomes as leadership priority	• Sponsor and invest in anti-racism education across the organisation to ensure all systems are racially literate • Make the gaps visible through a racial & ethnic health equity dashboard reviewed at board and executive meetings
A2	Demonstrate leadership by naming racism and taking accountability for addressing it	• Identify systemic racist bias across the continuum of care and name this • Sponsor quality improvement work to address the systemic biases that prevent birthing women from receiving the care they need
A3	Enact system-wide approaches to address causes of the causes of institutional racism	• Conduct a systems analysis to locate elements of institutional racism that could be modified • Provide protected time to staff in quality improvement projects to make anti-racism work a priority

B. Integration of Anti-Racism Approaches in Improvement Efforts

Anti-racism approaches must be an integral part of quality improvement efforts and not seen as two separate components of the work. This begins at the start, with the involvement of racially minoritised individuals in the work. It is important that the improvement team itself is racially diverse, and that individuals on the team actively acknowledge one's own racial, economic, and cultural biases and privilege. This should extend beyond representation alone and be embedded throughout the improvement process, from identifying the problems and designing change ideas to measuring impact, ensuring improvement efforts actively address rather than reinforce the existing inequities.

	Secondary Driver	Change Ideas
B1	Involve racially minoritised individuals in every stage of development	• Ensure improvement team is racially diverse and representative of the population being served • Actively acknowledge one's own racial, economic, cultural biases and privilege • Consider including women in population of focus as members of QI team • Co-partnership around shared aim • Involve people with lived experience in defining what success looks like (aim of the work), developing change ideas, and success measures • Increase awareness of initiatives for birthing women

B2	Identify racist bias and apply race-critical lens to the improvement work	• Use Anti-Racism Model for Improvement (MFI-AR) to guide improvement efforts and QI initiatives • Within improvement team, consider the ways in which racism impacts the lives of patients – both broadly and specifically within the clinical focus area of perinatal mental health • Acknowledge institutional racism • Pressure-test all change ideas through a race-critical lens that identifies and acknowledges power disparities • Ensure that discussions with women about this work are led by anti-racism experts with lived experience of racialisation and who are trauma-informed • Identify racist bias in decision-making process
B3	Debias and refine guidelines	• Analyse key guidelines for relevant clinical focus area centring on anti-racism and refine accordingly • Debias maternal mental health referral guidelines • Debias organisation's current Perinatal Mental Health guideline • Staff training to increase awareness of risks and actions based on debiased guidelines and protocols

C. Reliable Delivery of Debiased Clinical Guidelines and Protocols

This primary driver focuses on the reliable delivery of debiased clinical guidelines and protocols, consistently applied across races and ethnicities.

Based on the above guidelines and frameworks, teams should look at and analyse their compliance data disaggregated by race and ethnicity to see where the greatest opportunity to close process-related gaps exist. Teams should then start in areas of care within their sphere of control is greatest for impact (e.g. what's in teams' gift to affect), being aware of any unconscious bias or assumptions based on race and ethnicity when going through each guideline or protocol.

Additionally, while certain elements of the above guidelines and frameworks have been highlighted below, it is suggested that improvement teams go over entire set of guidelines and frameworks around preterm births above to determine which specific areas lead to highest variability across perinatal mental health and focus change ideas on these specific areas. As guidelines have been summarised below for brevity, please refer to full guidelines above when choosing change ideas.

	Secondary Driver	Change Ideas
C1	Interventions during pregnancy	**Increase awareness for both women and staff of perinatal mental health** • Parent education classes • Workshops

		• Resources • Crib sheets for midwives to increase confidence and normalise mental health discussions • Circulate service information to all GP surgeries • Focused parent education classes for black birthing women **Increase referrals to perinatal mental health services** • Simplify pathway and clarify referral criteria to develop a clear referral pathway • Develop guidance on referrals • Increase referrals to mental health services amongst staff with low referral rates • Improve conversations about mental health to increase disclosure and referral **Increase access to perinatal mental health services** • Improve links and partnerships with community-based organisations • Closer relationships with partner organisations led by consultant midwives • Build and strengthen relationships with GPs • GP communications re: simplified pathway and referral criteria **Standardised delivery of clinical guidelines across all races/ethnicities** • NICE Guidelines & protocols • Debias referral guidelines to increase referrals of Black birthing women
C2	Interventions during birth (admission to discharge)	(N/A)
C3	Interventions post-partum (beyond discharge)	**Increase awareness for both patients and staff of postnatal mental health** • Parent education classes • Workshops • Resources • Crib sheets for midwives to increase confidence and normalise mental health discussions

		Increase referrals to postnatal mental health services • Clear referral pathway • Develop guidance on referrals **Increase access to postnatal mental health services** • Improve links and partnerships with community-based organisations • Build and strengthen relationships with GPs **Standardised delivery of clinical guidelines across all races/ethnicities** • NICE Guidelines & protocols

D. Close the Equity Gap in Experience of Care for Service Users

Deep discussions with women by trauma-informed staff during the LAN revealed powerful opportunities to close the equity gap in experience of care of women. This begins by centring the perspective of women within the population of focus, building trust and safety, and meaningfully involving racially minoritised individuals in all parts of the work. This means creating safe and accessible opportunities for people to share their experiences, particularly for those whose voices have been historically overlooked or excluded.

	Secondary Driver	Change Ideas
D1	Centre perspective of service users in the population of focus	• Conduct three-part data review (quantitative, qualitative staff and patient) at the start of the QI project • Engage in meaningful dialogues with women, led by trained facilitators who racially and ethnically reflect the population of focus and shared lived experience • Co-produce outputs (e.g. education videos and multi-media) with women, in their local languages • Develop co-produced resources to support conversations about mental health • Follow-up calls with women about their mental health
D2	Build and strengthen trust and safety	• Create safe and trusted, trauma-informed spaces for birthing women to talk about their mental health and experiences • Partner with trusted community organisations, faith leaders, and cultural healers – going to community spaces, not just having women come to clinical settings • Provide clear explanations of diagnoses and treatments in preferred languages • Build engagement, empowerment and trust by seeing women as partners

		• Train staff to avoid racialised assumptions about mental health – instead seeing women as partners • Close the feedback loop in QI – communicate what actions were taken as a result of qualitative interviews, three-part data review, etc.
D3	Meaningfully involve racially minoritised individuals in all parts of the work	• Involve people with lived experience in defining what success looks like (aim of the work), developing change ideas, and success measures • Expert-led, race trauma-informed qualitative exploration of the experiences of racialised birthing women and families who experienced maternal mental health challenges

E. Stratified Data Across Race and Ethnicity for Improvement

The only way to determine whether improvement has occurred is through data—specifically, data stratified by race and ethnicity across both process and outcome measures. Teams in the LAN consistently identified data limitations as one of the most significant challenges in this work. For this reason, it is essential to assess what stratified data is available early in the improvement process and to partner with relevant stakeholders to ensure timely access to accurate, up-to-date data throughout the initiative.

	Secondary Driver	Change Ideas
E1	Collect, analyse, and publish data that is disaggregated by race and ethnicity	• Ensure QI team has access to disaggregated process and outcome level data by race and ethnicity, and able to analyse gaps in care between population of focus and white population • Create sustainable process or system of reporting and analysing data to look for improvement (e.g. trends and shifts) based on the QI work
E2	Ensure frequency of stratified data supports pace of improvement (e.g. weekly, monthly)	• Ensure data supports pace of improvement, e.g. weekly or monthly reporting of real-time data (vs. historical data from 1+ years previous)
E3	Create an anti-racism dashboard of key metrics, linked with patient safety	• Explicitly link anti-racism with patient safety and support through data • Track and communicate racialised patient safety indicators, e.g. reports of discrimination, dismissal of pain, delayed diagnosis, etc. • Create QI and leadership dashboards of key measures

4. Prioritising Changes: Where Do We Start?

Prioritising changes goes back to your aim: what are you trying to accomplish? Working backwards from there, each team will choose and prioritise change ideas for testing and improvement. Questions to consider prioritising changes are:

- What is in our scope of control to impact within the length of this project/programme? What is in our team's gift to affect?
- What changes are our disaggregated data pointing us to (when data is disaggregated by race and ethnicity)?
- What matters most to the birthing women we are serving in the Black, Asian, and minority ethnic group populations?
- Where is the greatest potential for impact towards our aim?
- Where is there already will and champions in our organisation?

Teams in the LAN were not expected to test all listed change ideas during the programme. Consider this a menu of options from which you may choose what to tackle first based on the 7 Anti-Racism Principles that embed this work and the questions raised above.

Other QI tools may be utilised along with your current state assessment to help you decide where to start:

1. Pareto chart: A type of bar chart in which the various factors that contribute to an overall effect are arranged in order according to the magnitude of their effect. This ordering helps identify the "vital few" — the factors that warrant the most attention, regarding which are the highest contributors of greenhouse gas emissions in your clinical setting.
2. Priority matrix: A tool that can better help you to understand important relationships between two groupings (e.g., steps in a process and departments that conduct that step) and make decisions on where to focus.
3. Impact-effort matrix: A tool that helps identify which ideas seem easiest to achieve (least effort) with the most effects (highest impact). The ideas identified via this tool would be a great place to start.

Measurement Guidance

How Will We Know if a Change Is an Improvement?

Measurement is a critical part of knowing if we have made a difference, what the impact of the changes are, if we have met our aim, and what action to take next. When selecting measures, it is vital to include the people whose lives will be impacted by the improvement to have a voice in deciding what measures are important from their perspective. While aims often centre around a quantitative aim or target, it's important to also measure improvement work using both quantitative and qualitative data.

Measurement for improvement should not be confused with measurement for research. This difference is outlined in the table below.

	Measurement for Research	Measurement for Learning and Improvement
PURPOSE	To discover new knowledge	To bring new knowledge into daily practice
TESTS	One large "blind" test	Many sequential, observable tests centred on learning
BIASES	Control for as many biases as possible	Design data collection to stabilise bias
DATA	Gather as much data as possible, "just in case"	"Just enough" data gathered through small sequential samples

As this work focuses on tackling the gap in ethnic inequality for maternal and neonatal outcomes, two core principles are critical in teams' quality improvement efforts:

1. **Collecting and analysing process and outcome data that is disaggregated by race and ethnicity** to identify where the greatest opportunities lie in tackling the gap in ethnic inequality across the four clinical focus areas and focus improvement efforts
2. **Use of qualitative data to understand experience of women and family, centred on equity and anti-racism**

Disaggregating data (stratification) to show potential systemic inequities is a critical strategy for ensuring that improvement efforts close rather than maintain or widen equity gaps (e.g., race, ethnicity, language, etc).

Selecting Outcome Measures

Linking back to the numeric goal within the aim statement, the outcome measure indicates how the system is working, specifically the impact on the service user / patients. Typically, there is one outcome measure for an improvement initiative, and at times, there may be a need for two.

Example outcome measures based on LAN team measures include the following:

East London Foundation Trust:

- Referrals received by Perinatal Community Teams from Black and Black British Backgrounds as defined by number of referrals received/number of referrals received for women from Black and Black British backgrounds

North Central London:

- Percentage of perinatal mental health referrals for Black women in N15 and N17 postcodes out of total population referred (where numerator = Black women referred in N15/17 in month; and denominator = All women referred in N15/17 in month

University Hospitals of Leicester:

- Increased referrals for South Asian women and birthing people accessing the service by 20% (i.e. from 2023-24 average of 10% of total clinic users to 12%) – measured by attendance.
    - Definition: number of women who attended MINT (Mental Health Int. Network) clinic, based on UHL monthly clinic user report, who identify as Asian/Asian British Bangladeshi, Pakistani, Indian, Mixed White and Asian or Any Other Asian Background. Numerator: number of South Asian women who attended the service month on month. Denominator: Total number of women who attended the service month on month.

Additionally, qualitative measures of birthing women's experiences are critical to this work and should be guided by the team's aim. When gathering this information, it is important to take a trauma-informed approach, recognising that discussions about care experiences, particularly where racism may have played a role, can be emotionally charged and potentially retraumatising. Teams should ensure that these conversations are conducted safely, sensitively, and with appropriate support available for both women and staff. Example questions used by one team include the following:

- What were good aspects of your care?
- What were some of the not-so-good aspects of your care?
- What would good care look like and feel like for you?
- How can we improve on the service we provide to ensure harm is reduced?
- What aspects of care should we consider as not to cause harm in mental health?
- Did you find your care to be culturally sensitive?
- Is there anything else you want to share with us to help improve how Black African and Caribbean birthing women can access the service?

Selecting Process Measures

Process measures assess whether the parts/steps in the system are performing as planned to achieve the aim. They help measure whether you are on track in your efforts to improve the system around perinatal mental health. Select your process measures based on the part of the process or system your data suggests needs improvement to achieve your aim, while considering what is within your team's ability to influence. Ensure that process-level data includes race and ethnicity and disaggregate this data by race and ethnicity when analysing your results.

Example process measures based on LAN team measures include the following:

East London Foundation Trust:

- Referral source of referrals received by Perinatal Community Teams from Black and Black British Backgrounds

North Central London:

- Percentage of Black women in N15 and N17 postcodes where perinatal mental health challenges have been detected

University Hospitals of Leicester:

- Overall referrals to Perinatal mental health services to 10% of all pregnancies – measured by attendance
- Number of GP referrals to MINT clinic and LPT maternal mental health services and LPT perinatal mental health services
- Number of referrals to MINT clinic from within UHL

Selecting Balance Measures

Balance measures help you identify whether changes made to improve one part of the system are causing unintended consequences elsewhere. Select measures that will help you monitor for unexpected effects of the change you are testing. Example balance measures based on LAN team measures include the following:

East London Foundation Trust:

- DNA Rate comparison at Perinatal Community Teams comparing Black and Black British groups with all groups

North Central London:

- Percentage of women in N15 and N17 postcodes where perinatal mental health challenges have been detected
- Percentage of perinatal mental health referrals for all women in N15 and N17 postcodes out of total population referred

University Hospitals of Leicester:

- Service user feedback on perceived quality of care within both UHL and wider LPT (Qualitative data from LPT and MINT clinic 'would I recommend the service to family or friends')

Suggested Family of Measures for Perinatal Mental Health

Outcome Measures	Process Measures	Balance Measures
• # of birthing women from Black, Asian, and minority ethnic communities who access perinatal mental health services	• % of birthing women from Black, Asian, and minority ethnic communities receiving **timely screening** for perinatal mental health issues • **Referral rate** to perinatal mental health services (disaggregated by race/ethnicity)	• Average waiting time to see specialist • Access rates among non-target groups • Proportion of overall referrals from different ethnic groups (to ensure equitable representation, not just higher numbers)

	• # of birthing women **accessing** perinatal mental health services once referred • **Confidence** of midwives and staff in discussing mental health issues with birthing women (survey)	• # of women admitted due to perinatal mental health condition • Referral declined rates (inappropriate referrals)

Getting Started with Measures: Practical Guidance

Look at your data disaggregated by race and ethnicity to identify where the greatest points of opportunity are for improvement. Use these findings to develop your aim and select corresponding outcome measures; process and balancing measures to assess whether your changes are leading to improvement without adversely affecting other parts of the system.

We understand that not all measures may currently be available to analyse by race and ethnicity. As a first step, assess your current state by identifying which outcome and process measures are already being collected and whether the data can be disaggregated and analysed by race and ethnicity.

Start with the women currently in your unit. Review their patient records, confirm with women whether race and ethnicity is correct. If race and ethnicity is not currently documented, ask women to self-identify their race and ethnicity and record this information. Continue this approach with all new women so that moving forward, completeness of patient records include race and ethnicity data, and enable relevant outcome and process measures to be disaggregated by race and ethnicity.

Use PDSA cycles to test your approach collecting qualitative data. Determine where in the process this will happen and test the process using a small scale PDSA (e.g. 1-3 women to begin with). Using the learning from those initial PDSA cycles, refine the qualitative questions and test these questions with a larger number of women. Continue to refine the questions and process until team has a high degree of belief that these are the “right” questions to ask in the right way at the right time for your population of focus, making sure it captures women’s experience information related to equity, race, and ethnicity and improve the process and system in a meaningful way.

Considerations for Spread and Scale

When considering how to spread change ideas to another unit or system; or scaling regionally or nationally, consider the following learning from LAN teams:

Spreading to Another Unit or System:

Prenatal:

- **Increase awareness for both women and staff of perinatal mental health**

Parent education classes - culturally tailored parent education classes are available within our sector. Whilst these don't specifically focus on mental health, these are successful and we would have liked to explore enhancing the discussion about mental health
Crib sheets for midwives to increase confidence and normalise mental health discussions - we trialled this with success with one clinical team. However, this would need trialling in another setting and refining.

- **Standardised delivery of clinical guidelines across all races/ethnicities**
  We started early work in this and saw there was significant potential to change and improve care nationally, but this work remains in the very early phase, and more testing and trialling would need to be done before scaling more broadly.
- **Debiasing maternity guidelines**
  We started early work in this and saw there was significant potential to change and improve care nationally, but this work remains in the very early phase, and more testing and trialling would need to be done before scaling more broadly.

Postnatal:

- **Increase awareness for both patients and staff of perinatal mental health**
  Crib sheets for midwives to increase confidence and normalise mental health discussions - we trialled this with success with one clinical team. However, this would need trialling in another setting and refining. For postnatal care, this could be scaled to include health visitors and the broader MDT.

Conclusion

This change package provides a framework to support teams in improving perinatal mental health. The change ideas should be tested, adapted and refined to meet the needs of people using services, staff and the local context.

Teams are encouraged to use quality improvement methods to test changes, measure impact and learn what works. Meaningful involvement of people using services, families, carers and staff should remain central throughout.

Improvement is an ongoing process. Teams should regularly review data, share learning and embed successful changes into routine practice to support sustainable, person-centred care.

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