



NHS Race and Health Observatory Learning Action Network Programme Pilot Evaluation Report

April 2026

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2. Executive Summary

2.1. Programme background

The Maternal and Neonatal Learning and Action Network (LAN) was launched to address the inequalities seen in severe maternal morbidity, perinatal mortality and neonatal morbidity for people from Black, Asian and other minority ethnic backgrounds. The programme was delivered in partnership between the Race and Health Observatory (RHO) and the Institute for Healthcare Improvement (IHI).

The programme tested a novel approach: embedding anti-racism principles within established quality improvement (QI) methodologies to identify, de-bias, and improve clinical practices in four key clinical areas (postpartum haemorrhage, maternal mental health, gestational diabetes, and preterm births).

It supported ten teams from NHS maternity service and mental health organisations, from eight Integrated Care Systems (ICS) to design and implement an anti-racism QI programme in local settings.

Programme content focused on technical training in the Model for Improvement (IHI's standard QI methodology) and providing guidance on how to embed anti-racism principles to actively de-bias healthcare practices. Support for QI project teams included monthly online all-teams calls, in-person all-team learning events, and team-based coaching with QI maternity experts.

2.2. Evaluation objectives and approach

The evaluation, delivered by the Health Innovation Network (HIN) South London and UCLPartners, aimed to:

1. Assess the feasibility and acceptability of the anti-racism focused QI approach.
2. Understand contextual factors to inform spread and scale in future phases.

The evaluation utilised a multi-stakeholder, mixed-methods approach, incorporating interviews, focus groups, surveys, and observations of LAN sessions. Data analysis was grounded in the MUSIQ-AR framework—an adaptation of the Model for Understanding Success in Quality, modified to include the RHO's seven anti-racism principles.

2.3. Evaluation Findings and Recommendations

Findings below presented below correspond to questions within each core evaluation objective.

Did the programme have a clear statement of aims and objectives, shared by stakeholders?

Across stakeholders and programme documentation, expressions of the LAN programme aims and objectives differed. These differences centred around whether the programme primarily aimed to achieve improvements in clinical outcomes, or to assess the feasibility and acceptability of the programme's novel anti-racism embedded quality improvement (QI) approach.

- Combining programme stakeholder perspectives, a view emerged of high-level programme objectives focused on process outcomes, clinical outcomes, feasibility and acceptability, and broader learning for application at scale.
- Project teams understood there to be dual objectives of reducing inequalities in health

outcomes, and contributing to change packages for spread and scale. Teams gained clarity on the programme's objectives at different times, which caused confusion during early stages of the programme for some.

How well does the programme design align with the intended programme objectives?

Overall, the programme design aligned well with its objectives.

- The use of the Learning and Action Network (LAN) approach was aligned with the objective of consolidating and packaging learning to provide a practical course of action (change packages).
- Integrating anti-racism principles into the Model for Improvement (Mfi) provided a pragmatic data-driven approach that supported QI project implementation. However, there were some alignment issues with certain clinical focus areas concerned with longer-term, system level pathways.
- The programme's four clinical areas provided a critical mass of learning for change package development in some areas, however some were less well represented (e.g., pre-term birth and gestational diabetes) which limited alignment with this goal.
- Operating within low resource settings without additional project funding impacted the feasibility of implementing QI projects as intended.

How effective and appropriate were processes for forming local teams and selecting QI projects?

Processes for forming local teams varied across the cohort, leading to diverse team compositions with varying degrees of suitability for anti-racism embedded QI project delivery.

- Processes depended on who completed the programme application process, who led team selection, levels of access to formal programme documentation to inform team selection, and availability of relevant expertise within project contexts.
- Successful teams included a mix of clinical leaders, dedicated QI and data experts, and non-clinical project managers who could maintain momentum. Gaps in specific clinical roles (e.g., obstetricians, anaesthetists) and senior leadership support hindered progress.
- Ethnic composition of teams varied, with global majority representation seen as critical for anti-racism work. Lived experience engagement was mostly limited to early project data capture, though some teams successfully embedded lived experience partners using existing Trust infrastructure.

How effective and appropriate were the processes for selecting teams/sites?

Project selection processes were largely acceptable and feasible, however programme clinical focus areas did not always align with local priorities or feasible project focus areas.

- Project selection was ultimately framed by the programme's four predefined clinical areas focused on morbidity. While this ensured a clinical focus to feed into change package development, the appropriateness of these fixed clinical areas received mixed feedback in terms of project acceptability and feasibility.
- The programme utilised a structured three-part data review—combining quantitative analysis, professional insights, and lived experience—to help teams identify appropriate clinical focus areas, and to inform project design and delivery. Supported by dedicated coaching, most teams saw the approach as acceptable, however some teams challenged the feasibility due to the process being time intensive and requiring specialist input.

Has the training, development and support led project teams to feel equipped to implement anti-racism focused QI in their local services?

The training and support package—comprising coaching, webinars, and in-person sessions—was widely praised for its high quality and relevance to project delivery. The effectiveness of the offer was constrained to some extent by logistical challenges, and a steep learning curve for those new to quality improvement (QI).

- Most participants found the technical QI training appropriate and 'pitched at the right level' for those new to QI. For those without prior QI experience, the learning curve was described as "steep." Sessions focused on de-biasing healthcare and understanding institutional racism were highlighted as particularly helpful and directly relevant to project delivery.
- The programme schedule presented barriers to full engagement, and most teams found attending all pre-set sessions unfeasible.
- Some felt the programme successfully built the psychological safety required for the sensitive nature of working through an anti-racism lens, while others felt at times that psychological safety within the LAN cohort was compromised.

Project implementation factors

Project teams reported a series of enablers and barriers to QI project implementation.

- **Key enablers included:** appropriate multi-disciplinary teams (including clinical representation, data, QI and anti-racism expertise, project management support and senior leadership), access to quality ethnicity disaggregated data, supportive organisations with existing cultures QI and/or anti-racism, access to resources for change idea implementation, and appropriate resources for patient and public involvement and engagement (PPIE).
- **Key barriers included:** poor access to quality disaggregated ethnicity data, working in complex and longer-term pathways, challenges with cross-organisational working, QI project team and broader workforce capacity and time constraints, staff turnover, institutional racism, and lack of adequate resourcing for project implementation.

Programme outcomes

Some projects achieved goals related to process-level changes, including:

- **De-biasing protocols** e.g., updated policies and risk assessments to remove bias, with some changes becoming routine;
- **Culture shifts** around increased acknowledgment of racial health inequalities within their organisations, including from senior leaders, and;
- **Staff capacity building** regarding technical aspects of QI, and empowerment to speak up about inequality and to apply an anti-racism lens to other areas of maternity care improvement.

Because the evaluation did not analyse validated clinical data, and due to the early stage of implementation, **a full picture of clinical outcomes cannot be provided.**

However, one team reported making **a positive impact on measures relating to post-partum haemorrhage** resulting in parity across ethnicities. Other teams are at the stage of measuring potential effects of their change ideas, and therefore it's too early to determine any implications for clinical outcomes.

Recommendations for future delivery of the Maternal and Neonatal LAN are provided under each theme in Section 5, and an overview of co-developed recommendations for anti-racism QI project implementation is provided in Section 6 (see Appendix 7.6 for full recommendations).

3. Programme background

3.1. Programme context

Data consistently show higher rates of perinatal mortality and morbidity amongst Black, Asian and minority ethnic women and babies compared to their White counterparts. At the time of programme inception, there was nearly a three-fold (3.8 times) difference in relative rates of maternal mortality amongst women from Black ethnic backgrounds and an almost two-fold (1.8 times) difference amongst women from Asian ethnic backgrounds compared to White women.¹

Despite this persistent disparity, England has seen few large-scale health improvement initiatives aimed specifically at addressing these ethnic health inequalities. Crucially, the evidence base for scaling up the effective approaches that do exist remains limited, hindering widespread and sustained progress.

3.2. The Maternal and Neonatal Learning Action Network

To address this gap, the Maternal and Neonatal Learning and Action Network (LAN) was launched. This pilot programme was a partnership between the Race and Health Observatory (RHO) and the Institute for Healthcare Improvement (IHI), funded by the Health Foundation (HF). The programme utilised an established quality improvement (QI) approach², embedding anti-racism principles to tackle systemic inequalities within maternity and neonatal services.

The LAN was designed with three core aims:

- developing an anti-racism focused quality improvement (QI) model, that supports practitioners to identify and address institutional racism within maternity services;
- identifying and sharing improvement approaches that embed anti-racism into maternity services and improve maternal and neonatal health outcomes, and
- undertaking research to understand factors influencing effectiveness and scalability of the anti-racism QI model for maternity services.

The LAN programme supported ten teams from NHS maternity service and mental health organisations, from eight Integrated Care Systems (ICS), the bodies responsible for local health and care planning, to deliver an anti-racism embedded QI project. Support for QI project teams included monthly online all-teams calls, in-person all-team learning events, anti-racism focused webinars, and team-based coaching with QI maternity experts. Programme content focused on technical training in the Model for Improvement (IHI's standard QI methodology) and providing guidance on how to embed anti-racism principles to actively de-bias healthcare practices.

¹ The [most recent MBRRACE-UK figures](#) (published January 2026) indicate a nearly three-fold difference amongst women from Black ethnic backgrounds, and a non-significant difference between women from Asian and White ethnic backgrounds.

² The '[Model for Improvement](#)' is an improvement approach supported by the Institute for Healthcare Improvement, and adopted within the Maternal and Neonatal Learning Action Network.

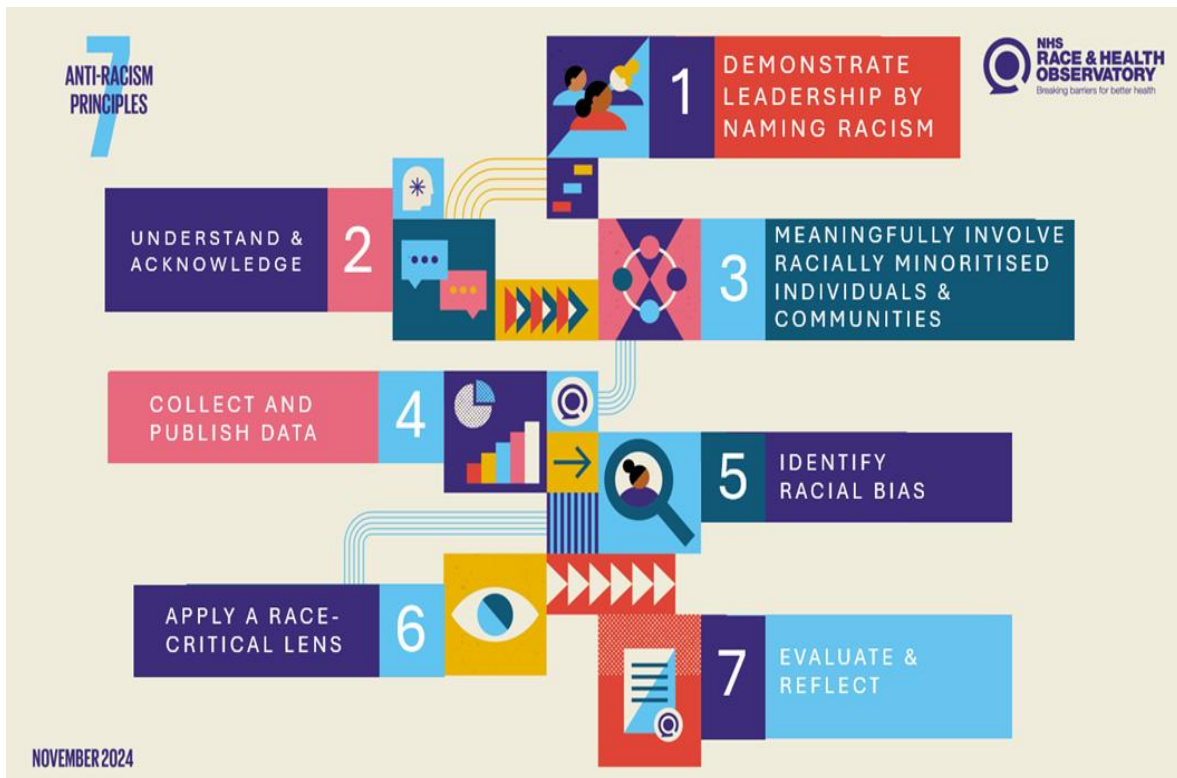
Each team selected a specific topic to address, taken from four identified perinatal (the time during and after pregnancy) clinical conditions, with the aim of improving care for women from Black and minority ethnic backgrounds:

- Gestational Diabetes
- Postpartum Haemorrhage
- Maternal Mental Health
- Preterm Births

Each team identified its own aims and metrics to measure the success of its work. Insights generated from these local interventions were expected to indicate what works best across diverse populations, enabling the development of evidence-based packages that can be offered for wider adoption across NHS England and Wales.

The LAN programme was conducted in alignment with the RHO's seven anti-racism principles, outlined in **Figure 1**.

Figure 1 RHO's seven anti-racism principles³



³ [Principles published by RHO](#), November 2024

4. Evaluation

[Health Innovation Network South London](#) (HIN) in partnership with [UCLPartners](#) (UCLP) was commissioned to deliver an evaluation of the Maternal and Neonatal Health Learning Action Network pilot programme (LAN). The following section outlines the evaluation’s objectives and approach, including design, methods, and analysis.

4.1. Evaluation Objectives

The evaluation’s purpose is to help the Race and Health Observatory (RHO), Institute for Healthcare Improvement (IHI), and Health Foundation understand whether an anti-racism approach embedded within QI methodology is a successful mechanism for effectively addressing the persistent ethnic inequalities in maternal and neonatal health.

The **core aims of the evaluation** are as follows:

1. To understand the **feasibility and acceptability of an anti-racism focused improvement approach** to address ethnic inequalities in maternal and neonatal health.
2. To work with RHO and IHI teams to develop an evaluation protocol **to understand contextual and implementation factors that affect the effectiveness and scalability of interventions** developed through the anti-racism focused LAN approach, to inform subsequent phases of the programme.

The evaluation included a scoping phase to amend evaluation objectives outlined in the original invitation to tender (ITT). Final evaluation objectives reflect findings from scoping phase interviews, observation of meetings and other events, and document review. The evaluation objectives sit under two core aims outlined in **Figure 2** (see **Appendix 7.1** for a detailed list of evaluation objectives and corresponding questions).

Figure 2 Evaluation aims and objectives

Aim 1: To understand the feasibility and acceptability of the approach

1. To evaluate the programme design and rationale
2. To evaluate the process of project team selection and formation
3. To evaluate the problem/project identification for project teams
4. To evaluate the training, development and support for project team staff to carry out anti-racism focused QI
5. To evaluate the implementation and early outcomes of local QI activities

Aim 2: To inform scale and spread in subsequent phases of the programme

1. To develop an explanatory theory of how the anti-racism focused QI approach works
2. To make recommendations for spread, scale and sustainability, including lessons learnt

4.2. Design and methods

Evaluation advisory group

The evaluation was steered by an internal advisory group including minority ethnic lived experience partners and experts in anti-racism. The advisory group played a critical role in steering the evaluation design and approach, including evaluation methodological and analytical approaches. Critically, the group was expressly tasked with challenging the predominantly White British evaluators to ensure the evaluation remained reflective and purposeful in approaching topics related to race, ethnicity, and racism.

The evaluation advisory group included experts in:

- Maternal and Neonatal service delivery, including the HIN's Obstetric Clinical Leads and midwives associated with the HIN.
- Patient safety and cultural competency
- Relevant lived experience within maternity and neonatal care
- Anti-racism
- Evaluation and implementation science

Methods

To answer the range of evaluation objectives, the evaluation adopted a mixed methods approach, combining findings from different data sources, including:

- **Qualitative semi-structured interviews** with project team leaders, the RHO/IHI programme team and broader stakeholder groups.
- **Focus groups with project team members** from nine of the ten LAN project teams.
- **Ethnographic work** including structured observation of convened meetings, training and support sessions and webinars
- **A survey of all project team members** conducted using the adapted MUSIQ-AR Excel tool (see theoretical framework section). One survey was completed collaboratively by each project team at a LAN all-teams learning event.
- **Review of documents and recordings** relating to the planning, implementation and impact of the LAN programme and the ten projects.

The evaluation initially intended to conduct secondary analysis of quantitative and qualitative data gathered by the project teams as part of their QI interventions, including feedback gathered from maternity service users. Due to a lack of access to project team data, this aspect of the evaluation was not carried out.

Theoretical framework

The evaluation used the **Model for Understanding Success in Quality (MUSIQ)**⁴ framework (and modifications incorporated within MUSIQ 2.0⁵). This framework was created to help organisations and researchers understand how different contextual factors—such as organisational culture, team dynamics, and external support—influence the success of healthcare quality improvement (QI) projects.

The MUSIQ framework was selected because:

⁴ Kaplan HC, Provost LP, Froehle CM, Margolis PA. [The Model for Understanding Success in Quality \(MUSIQ\): building a theory of context in healthcare quality improvement](#). *BMJ Qual Saf*. 2012 Jan;21(1):13-20. DOI: 10.1136/bmjqs-2011-000010. Epub 2011 Aug 10. PMID: 21835762.

⁵ Reed, J.E., Kaplan, H.C. & Ismail, S.A. A new typology for understanding context: qualitative exploration of the model for understanding success in quality (MUSIQ). *BMC Health Serv Res* 18, 584 (2018). [DOI](#)

- **It is purpose-built for assessing QI projects.** Unlike broader implementation frameworks, MUSIQ was designed specifically for understanding the implementation of QI projects in complex contexts.
- **It is a validated and trusted tool** for assessing QI projects. It has been rigorously tested in clinical settings, including obstetrics.
- **It is designed for practical application.** The tool has been developed in an accessible format (Microsoft Excel) to enhance its application at scale.

Adapting MUSIQ for anti-racism

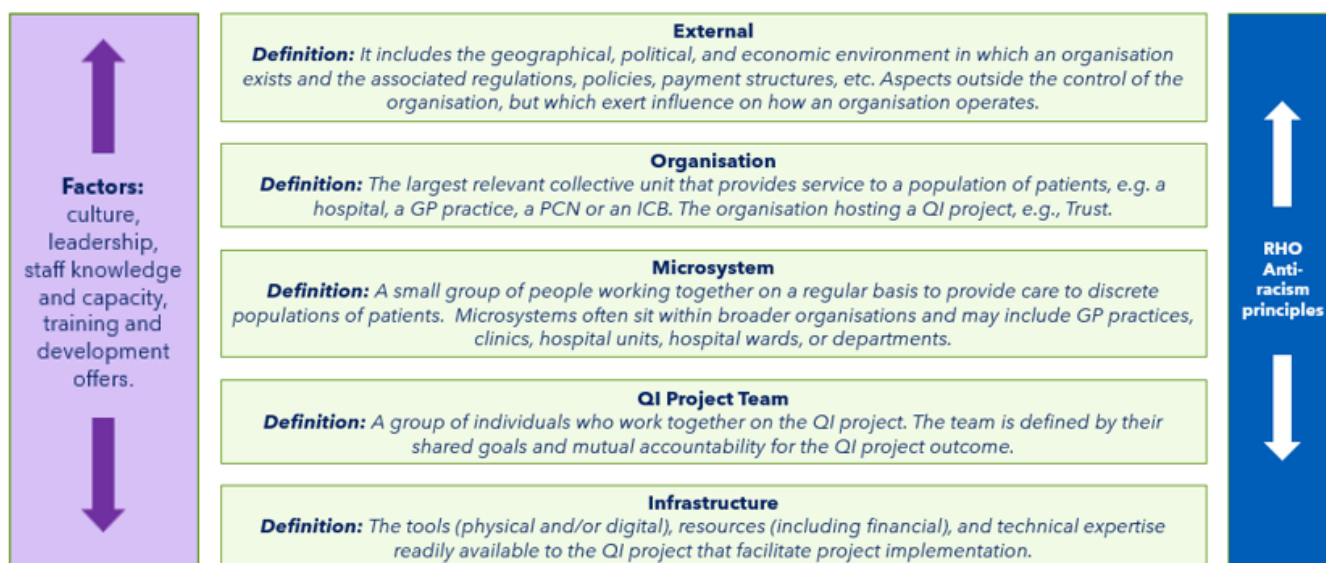
It was imperative that data collection and analysis within the evaluation incorporated an anti-racism focus to understand the impact of the programme on race inequalities. To align with the programme's core mission, the model was modified to incorporate the RHO's seven anti-racism principles.

The evaluation advisory group played a critical role in revising MUSIQ. Through an iterative process of discussion and design within workshops and periods of reflection, the group—facilitated by the core evaluation team—mapped the RHO anti-racism principles against existing MUSIQ domains and factors to create a bespoke framework (named MUSIQ-AR) to evaluate project success through an explicit anti-racism embedded QI lens.

A working group was convened in addition to the evaluation advisory group, with significant membership comprising people from Black, Asian and minority ethnic backgrounds, including people with relevant lived experience of maternity services, to support the adaptation of MUSIQ.

The group firstly familiarised themselves with both the RHO's anti-racism principles and the domains and contextual factors presented within MUSIQ. The group then worked to map the anti-racism principles to MUSIQ. While not all the MUSIQ contextual factors were adapted to incorporate an anti-racism lens, the resulting version of MUSIQ has all seven anti-racism principles interwoven. **Figure 3** visualises the interaction between MUSIQ domains, factors, and the RHO anti-racism principles. **Appendix 7.2** details all MUSIQ-AR domains and factors.

Figure 3 Adapted MUSIQ framework



Analysis

Data were structured and analysed using both MUSIQ-AR and evaluation questions as guiding frameworks.

- **MUSIQ-AR.** Structuring and analysing data using MUSIQ-AR helped the evaluation team derive specific contextual insights related to the implementation of QI projects, and critically ensured data capture and analysis employed an explicit anti-racism lens throughout the evaluation. The approach provided a consistent analytical approach across ten project sites and enabled the evaluation team to identify similarities and differences across sites.
- **Evaluation questions.** Where the evaluation aimed to answer questions related to programme delivery, detailed evaluation questions were used as a guiding framework for structuring and analysing evaluation data.

To support detailed analysis, qualitative data was coded using NVivo⁶, an industry leading qualitative data analysis (QDA) software used by evaluators and researchers to organise and analyse data. Data was also structured using Microsoft Excel, particularly for organising and comparing contextual factors related to QI project implementation.

Comparative case study methodology

Interview, focus group, and MUSIQ-AR survey data from project teams were used to construct a case study for each QI project. Case studies were focused on identifying the contextual enablers and barriers to project implementation within each project context, and were framed using MUSIQ-AR.

A comparative case study collects and analyses data from two or more 'cases' to understand how and why a programme works or fails to work. Generalisable knowledge can be produced about causal relationships by examining similarities and differences across different contexts. This methodology was chosen to enable us to address the core evaluation aim of understanding contextual and implementation factors that affect the effectiveness and scalability of QI interventions developed through the anti-racism focused LAN approach.

Original evaluation design intended to purposefully select four case study sites for comparative analysis. However, given all sites presented a unique context for project implementation, a collective decision was taken between the evaluation team, evaluation advisory group, and the RHO and IHI, to expand case study data collection and analysis to all ten participating project teams. With this adjustment in scope, a breadth of insight was emphasised as well as depth.

Cultural humility

Given the predominantly White British composition of the evaluation team, we adopted a rigorous approach to cultural humility to navigate the power dynamics inherent in evaluating an anti-racism QI programme. We maintained a practice of continuous critical reflexivity, explicitly acknowledging our own position and the potential for unconscious bias to influence the evaluation process. This involved regular internal review and challenge sessions to actively mitigate against racial bias across all stages—from study design and delivery through to analysis—ensuring that our interpretive lens prioritised the lived experiences of the programme participants rather than the evaluation team's normative perspectives.

Regular input from the evaluation advisory group and lived experience partners were critical to this approach.

⁶ <https://lumivero.com/products/nvivo/>

5. Evaluation findings

This section presents evaluation findings corresponding to each core evaluation objective. To help the reader navigate the report, evaluation objectives have been grouped into themes that reflect core aspects of LAN programme design and delivery, and QI project implementation.

Each subsection provides a high-level summary of key findings, followed by detailed findings and supporting data (in the form of quotes), and concludes with a set of related recommendations. Recommendations within **Section 5** have been formulated by the evaluation team, based on triangulation, analysis, and interpretation of data captured across stakeholders.

Section 6 provides an overview of programme level recommendations generated by stakeholders during a recommendations workshop attended by various stakeholders, which are presented in further detail in **Appendix 7.6**.

5.1. Programme aims and objectives

Summary of findings

- Programme stakeholders held different views regarding the programme's primary aim.
- In general, views were split between whether the programme primarily aimed to achieve improvements in clinical outcomes, or to assess the feasibility and acceptability of the programme's novel anti-racism embedded quality improvement (QI) approach.
- Considering all programme stakeholder perspectives, the evaluation understands LAN programme objectives to relate to QI project-level process and clinical outcomes, assessing the feasibility and acceptability of the anti-racism adapted QI approach, and capturing broader learning for application at scale.
- Project teams understood there to be dual objectives of reducing inequalities in health outcomes, and contributing to change packages for spread and scale.

Did the programme have a clear statement of aims and objectives, shared by stakeholders?

Programme stakeholder perspectives

Amongst programme level stakeholders, differences in understanding of programme objectives centred around whether the programme's primary focus was on clinical outcomes (i.e., reducing severe perinatal mortality and/or maternal morbidity) or on assessing the acceptability and feasibility of the programme's approach of embedding anti-racism principles within a QI approach.

RHO stakeholders, including those involved directly in programme design and delivery and those within the RHO Maternity and Neonatal Technical Expert Group, conveyed that they understood programme objectives would focus on achieving improvements in clinical outcomes. For example, a widely cited aim appears in the clinical driver diagram for the LAN programme (Dec 2023, see **Appendix 7.4**), which emphasises clinical outcomes and experience: "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." This aim focuses on clinical outcomes without explicitly mentioning goals related to testing feasibility and acceptability of anti-racism embedded QI. Additionally, formal programme selection criteria for project team applications (see **Appendix 7.3**) refer explicitly to the potential for teams to impact

clinical outcomes related to maternity.

In contrast, IHI stakeholders emphasised programme objectives focused on trialling and assessing the acceptability and feasibility of the anti-racism embedded QI methodology itself. This indicates that achieving improvement in clinical outcomes related to morbidity was understood to be a secondary and longer-term objective resulting from a successful QI approach, and not what the programme primarily set out to measure.

“We set out to learn what approaches work to implement an anti-racism lens through the work of maternity. We were also clear that in this kind of time frame, we would not be able to realistically impact on mortality, but certainly morbidity we would be able to have an impact.”

IHI programme stakeholder

Public and non-public programme documentation also reflected these differing views. There were variations in the extent and nature to which maternal morbidity, maternal mortality and non-clinical process objectives are referred to explicitly as programme objectives.

We note that objectives related to upskilling practitioners in anti-racism QI were not formally articulated as intended programme outcomes, despite this being an immediate and significant outcome of the programme (see **Section 5.7** for further discussion of programme outcomes).

Programme level metrics

The LAN programme did not develop formal outcome measurement infrastructure. While a high-level driver diagram was developed (see **Appendix 7.4**), no detailed Theory of Change or Logical Framework was established. Consequently, the evaluation team is unaware of any formal programme-level metrics or timeframes associated with process or clinical outcome objectives.

LAN participant perspectives

The RHO promoted the programme through videos shared on LinkedIn, and through a [LAN Information Pack](#) published on the RHO website (issued 22nd September 2023). The information pack provided detailed information for teams considering applying to the LAN about the programme background, structure, requirements, and timeframe.

Whilst the information pack does not refer to explicit programme or project level goals, it makes reference to several intended programme outcomes, including helping the ‘development and spread of effective approaches to addressing health inequalities in maternal health’, ‘accelerating local action on maternal health inequity’, and to ‘scale and spread good practice and contribute towards the development of a truly anti-racist improvement approach’.

The framing of the document suggests a primary programme focus of supporting the acceptability and feasibility of an anti-racism embedded QI approach, and contributing to change packages for spread and scale. However, subsequent in-person and online all-project meetings emphasised objectives relating to improving clinical outcomes, as well as contributing to change packages for spread and scale.

Project teams generally expressed an understanding of dual programme objectives focusing on a) implementing QI projects focused on reducing inequities in outcomes within maternity and neonatal services, and b) contributing to change packages for spread and scale.

“We expect that within a year's time we're going to have change packages that we're going to be able to share, where we will have developed some improvement ideas that we'll be able to scale.”

Project team member

Project teams generally understood the programme to be focused on both reducing inequity and change package development. However, how and when teams reached greater clarity was inconsistent. Most teams reported gaining a clear understanding of the programme's purpose and objectives only during or after the first in-person event in January 2024.

"I was told about this RHO LAN over Christmas by our programme director and I believe at that point we weren't 100% sure what the ask was going to be, what to expect. It was from the in person January event when we got more insight on what the expectations were." **Project team member**

In part, this variation may be accounted for by the way teams were selected and the degree individual team members were involved in the application processes. Whereas some members were involved from the Expression of Interest (EOI), others were brought onto teams at a later stage, months after project commencement. Therefore, there may have been challenges with sharing important programme documentation with all members of the final project team.

Several project team members agreed that more information on the details of programme requirements and expectations at an earlier stage would have been welcome.

Recommendations for programme implementers

1. Co-produce programme level objectives, metrics, and measurement approaches within early stages of programme design.

- Co-produce a programme implementation plan with relevant stakeholder. This plan will detail who should be involved in programme delivery, the financial and non-financial resources required, the mechanisms through which the programme will be delivered, programme accountability and governance, communication strategies, and over what time period delivery will take place (including detail of any explicit stages to delivery).
- Establish a detailed Theory of Change or Logic Model, co-produced with relevant stakeholders to arrive collectively at a shared understanding of programme aims and objectives. This should be established prior to programme implementation and inform programme design.
- Establish programme metrics, including at process and outcome level, identifying expected, short- medium-, and long-term outcomes.
- Establish a corresponding monitoring and evaluation approach to capture data aligned with agreed programme objectives and associated metrics.
- Future programmes should consider incorporating outcomes of upskilling staff in anti-racism QI as an explicit and targeted programme outcome.

2. Require application leads to cascade programme information and onboarding resources to all QI project team members.

5.2. Programme design

How well does the programme design align with the intended programme objectives?

Summary of findings

- The use of Learning and Action Network (LAN) was strategically well-positioned to actively test and learn new approaches, aligned with the objective of generating change packages.
- Integrating anti-racism principles into the Model for Improvement (Mfi) was largely an effective mechanism aligned to programme aims.
- The Mfi provided a pragmatic data-driven approach that supported QI project implementation, however some teams reported alignment issues with some clinical areas.
- The programme's training, development, and support offer was well aligned to equip teams with relevant skills to implement anti-racism QI projects.

This section provides an assessment of the extent of alignment between core aspects of programme design and intended programme outcomes. For the purpose of the evaluation, the **programme design was understood to encompass several key components:**

- a) Using the LAN approach to enable education and practical application of learning,
- b) Integrating anti-racism principles within an established quality improvement approach (the 'Mfi'),
- c) A comprehensive structure of education and support,
- d) Four clinical focus areas to focus project delivery and consolidate learning, and
- e) Allowing teams to implement projects with no dedicated project funding.

Alignment is considered as the extent to which design principles are deemed appropriate and relevant to achieve desired programme goals, and the extent to which design principles are acceptable and feasible to programme stakeholders. While this section focuses solely on alignment, further detail on stakeholder perceptions and experiences related to these areas are provided in subsequent sections of the report (references to relevant sections are provided in parenthesis).

Learning Action Network as a vehicle for programme delivery

The use of a LAN was strategically well-positioned to upskill project teams in QI methods and anti-racism approaches, and to enable teams to test and learn from implementing change ideas in a supportive environment.

- The LAN approach provided an enabling environment aligned with programme objectives to assess acceptability and feasibility of an anti-racism embedded QI approach, and consolidate learning to build change packages for spread and scale. Projects required teams to go beyond existing protocols, test new ideas, and gather evidence to influence changes to microsystem- and organisation- level policy and practice.
- The LAN format provided structured education and coaching over the course of the programme, which provided valuable opportunities for teams to learn new skills and reflect on practice and develop solutions to problems as they arose (see **Section 5.5** for more detail on stakeholder views of programme education and support).
- While overall adaptations to the programme were minimal, an essential level of flexibility and responsiveness was maintained throughout delivery. For instance, training content was adjusted to better align with the differing levels of baseline knowledge between participating teams

The Model for Improvement

The Mfl provided a pragmatic data-driven approach that supported QI project design, implementation, and outcome monitoring. It therefore aligned well with programme objectives to assess the acceptability and feasibility of implementing an anti-racism QI approach, and to bring about changes to clinical outcomes. However, project teams expressed mixed views regarding acceptability and feasibility. While broadly accepted as a practical framework, its feasibility varied significantly depending on the specific project context, resources, and clinical pathway involved.

- Most teams found the Mfl appropriate and valuable, praising its data-driven, project-based structure. The three-part data review⁷ and 'Plan, Do, Study, Act' (PDSA) cycles effectively helped teams identify priority clinical areas, define populations of focus, and test low-cost change ideas. This directly aligns with programme objectives to assess the acceptability and feasibility of anti-racism embedded QI, and to generate learning for change packages.
- The model was deemed appropriate for projects more immediately time-bound and focused on a contained clinical pathway (such as managing post-partum haemorrhage). It was deemed less feasible for complex, longitudinal pathways (e.g., pre-term birth and perinatal mental health) or interventions that were not strictly time bound. Challenges centred around project and outcome measurement, specifically that tools, such as statistical process (SPC) charts, did not align with project measures or sample sizes. Contextual factors also impacted on the feasibility of implementing PDSA cycles as intended (see **Section 5.6**).

"We are looking at a vast area for pre-term birth, and it didn't always fall into the time scales for PDSA cycles, because there was no quick win with our project. Things we were doing were going to take quite a lot of time to be able to evaluate their effectiveness...the requirement to present data in a certain way just didn't always work for us." **Project team member**

- While the principle of the three-part data review was accepted, the execution was resource-intensive for teams. Feasibility was undermined by the time required, a lack of quality ethnicity-disaggregated data, and/or the difficulty of shifting staff mindsets from an "audit" lens (perfection) to an "improvement" lens (iteration). A few team members questioned the acceptability of limited data and insight to inform changes to practice. Capturing patient qualitative and quantitative data was a particular challenge, especially for teams without dedicated data expertise and support. Some teams expressed reservations about basing project selection or change ideas on interviews with very small numbers of patients.
- Concerns were raised by a few team members that a localised QI approach is insufficient for tackling systemic issues like institutional racism. Participants felt that sustainable change requires a national mandate rather than fragmented efforts by individual trusts.

"If the approach came from government and there were policies in place, it would work a lot better, and it's probably more likely to have sustainability rather than individual trusts trying to do it."

Project team member

Anti-racism principles

Integrating anti-racism principles into the Mfl aligned with programme objectives to assess the acceptability and feasibility of an anti-racism QI approach, and to bring about equity in

⁷ The three-part data review included quantitative data analysis of system data to identify clinical priority areas and population(s) of focus, and qualitative patient and staff data collection and analysis to inform project design and implementation strategies.

clinical outcomes across ethnicities. The approach was generally well-received and acceptable to participating teams, however feasibility varied across projects.

- The decision to integrate clinical and racial equity aspects within a QI methodology drew on research, programme team learnings, and existing change packages from the US, including [Alliance for Innovation on Maternal Health \(AIM\) bundles](#). The goal was to ensure the approach deeply embedded anti-racism principles within a QI approach, avoiding racial disparities being overlooked or seen as a secondary consideration.
- The RHO anti-racism principles and related LAN education and reflection sessions, particularly those focused on de-biasing guidelines and protocols, directly informed project activity and were highly valued by teams. The approach provided clear guiding principles and implementation focus for teams, which ensured a racial equity lens was consistently applied to project design and delivery. The efficacy of this approach is evidenced by the nature and outcomes of the LAN QI projects (see **Section 5.7** on programme outcomes).
- The feasibility of applying anti-racism principles varied across projects. Teams operating within organisations and/or systems with existing cultures of anti-racism practice were more able to apply anti-racism principles in practice. Teams operating in contexts without that culture often found it difficult to have anti-racism informed conversations with senior leaders and frontline staff, and subsequently to influence a change in beliefs, knowledge, and practice. Resource constraints, infrastructure, and team composition were also factors that impeded feasibility of applying anti-racism principles in practice (see **Section 5.6** for more detail).
- A few team members raised concern that the LAN may unintentionally promote unethical practices by encouraging QI teams to engage with racially minoritised staff and patients without appropriate training around race, trauma-informed approaches, and safeguarding.

Programme education and support

The programme's training, development, and support offer was well aligned to equip teams with relevant skills to implement anti-racism QI projects. However, there were feasibility challenges around LAN session attendance due to workforce capacity constraints, fixed clinical schedules, and scheduling frequency.

- Education and support consisted of a comprehensive package of online team coaching calls, online 'all teams' meetings, in-person learning events, learning webinars, and various QI-related resources. Teams felt technical QI training was comprehensive and pitched at the right level for those new to QI. Anti-racism and de-biasing learning webinars supported the de-biasing of policies, guidelines, and protocols in practice.
- Feasibility challenges related to competing work priorities and limited capacity impacted full engagement with programme educational sessions and support across the cohort, particularly for busy clinicians with fixed schedules. Some clinicians reported having little time to 'absorb' the training, particularly when sessions were held at the end of the working day. **Section 5.5** details project team perspectives on programme education and support.

Programme clinical areas of focus

The selection of four clinical areas generally aligned with the programme's aim to address ethnic inequity in priority clinical areas. This structure can successfully facilitate peer-to-peer support and provide a "critical mass" of learning to inform the development of change packages. However, not all clinical areas had adequate representation across the cohort to enable this. Additionally, the complex and longer-term nature of perinatal mental health and pre-term birth pathways did not align fully with the Mfl.

- The goal of creating comprehensive change packages was hindered because not all clinical areas attracted enough participation. Only two of the four areas (post-partum haemorrhage - 4

projects and maternal mental health – 3 projects) secured a sufficient critical mass of projects to fully support this objective. See **Appendix 7.5** for an overview of project focus areas.

- Feasibility was lower for projects focusing on perinatal mental health, pre-term birth, and gestational diabetes. Change ideas in these areas could be difficult to implement and measure because they rely on complex, longitudinal pathways that often involve cross-organisational systems or long-term behaviour change.
- In contrast, clinical areas such as post-partum haemorrhage were found to be more feasible to tackle using a QI approach. These conditions are isolated to a specific, tightly time-bound part of the perinatal journey, allowing for more direct measurement and management.
- Whilst teams understood the approach of having four pre-determined clinical focus areas, for some it was felt to be overly restrictive, and impeded the ability to focus on an area of higher priority and feasibility within local systems.

*“There wasn't freedom and flexibility to have a personalised QI. If we had looked at our trusts as individuals, there might have been different areas we feel are most needed... we should have been allowed to discuss that and bring it forward.” **Project team lead***

QI project delivery without additional financial support

The lack of resource to support project implementation in some cases undermined alignment with programme objectives, and overall acceptability and feasibility. The low-resource settings some teams were operating within, coupled with a lack of upfront information about programme approach and required commitment, meant some teams did not feel appropriately resourced to implement projects optimally to align with stated goals.

- The significant time commitment required for the programme led some members to lose income or pay out-of-pocket for project attendance (e.g. travel). This financial burden may unintentionally create a barrier to access for participants from low-resource trusts or those unable to use personal finances to support their involvement.

*“As a team we didn't know really what we were walking into and how much was needed took us by surprise. It was an unanticipated resource of time that was required that hadn't been thought of. That needs to be more transparent moving forward.” **Project team member***

Co-producing programme design and delivery

The intention to co-produce the programme design with lived experience partners was stated within early programme documentation, but levels of co-production were limited. The reasons for lower than anticipated co-production are unclear. However, a possible barrier could have been the rapid pace and iterative nature of the programme's initiation.

Recommendations for programme implementers

1. Review programme clinical areas to ensure alignment and feasibility within the programme's timeframe and QI methodologies.

- Select project focus areas on clinical priorities that are more clearly time-bound, measurable, and implementable within the programme duration, avoiding complex pathways requiring significant cross-organisational working.
- Incorporate local priorities and experience into the process for selecting project focus areas to ensure acceptability and feasibility of chosen projects.
- Alternatively, create a "Complex Pathway" track with an extended timeframe and modified measurement expectations for topics like perinatal mental health, acknowledging that standard PDSA cycles may need adaptation.

2. Offer a more flexible menu of measurement tools and approaches while maintaining the core PDSA structure of the QI approach.

- Allow teams working on complex, qualitative, or small-cohort projects to use alternative validated measurement methods if standard Statistical Process Control (SPC) charts are not feasible or relevant to their specific data set.
- Qualitative methods and associated tools and frameworks should be considered as an alternative project monitoring methodology where quantitative methods are ill-suited.

3. Prior to commencing programme design, establish and adequately resource a co-production approach to programme design.

- This should involve all relevant stakeholders, including lived experience partners, clinical leadership representatives, and system leaders.
- Appropriate mechanisms for capturing and consolidating multiple stakeholder views should be established in advance.

4. To ensure ethical practice, the programme should develop and integrate a comprehensive ethical framework and associated guidelines specifically designed for anti-racism embedded QI activities.

- The framework should include mandatory guidance and training on trauma-informed approaches, safeguarding, and the specific sensitivities required for anti-racism work.
- This ensures that project teams – who may lack specialist QI expertise – can engage staff and patients safely, mitigating the risk of (re-)traumatisation or unintended harm during data collection and project implementation.

5.3. Project team selection

Summary of findings

- Processes for forming local teams varied across the cohort. This is reflected in a notable degree of variance in team compositions.
- The most successful teams included a mix of clinical leaders, dedicated QI and data experts, and non-clinical project managers who could maintain momentum.
- The ethnic composition of teams varied, with global majority representation seen as critical for anti-racism work. Lived experience engagement was mostly limited to project data capture, with some exceptions.
- System-level teams (e.g., Local Maternity & Neonatal Systems/ICBs) often struggled with accountability and frontline buy-in unless established working relationships already existed.

How effective and appropriate were processes for forming local teams?

Project team application process

The RHO published a [LAN Information Pack](#) on their website in September 2023, prior to submission deadlines for EOI and full applications. The information pack provided detailed information for teams considering applying to the LAN about the programme background, structure, requirements, and timeframe.

Prospective project teams were asked to complete an EOI before proceeding to submit a full application.

- The **EOI** asked applicants for the name and type of organisation, motivations for taking part in the LAN, an outline of the proposed project team and their roles, demographics of the population served and community setting, and activity undertaken by the organisation to advance equity and anti-racism.
- The **Full Application** asked applicants for more specific detail on the nature and scale of maternity services relevant to the application, and for more detailed information relating to participating in the LAN, including objectives, strategic alignment between LAN and organisational/system priorities, existing commitments to equity, team composition, and existing QI infrastructure.

Full applications were required to provide a supporting statement from a senior project sponsor (e.g., Group Chief Nurse, Director for Inclusion and Equity, Clinical Director for Maternity and Neonatal Services) within the relevant organisation.

Decision-making criteria for project team selection were developed by the RHO. These 'suggested criteria for evaluators' assessing project team applications outline three core areas for evaluating applications, including 'potential for impact', 'commitment to anti-racism', and 'organisational readiness' (see **Appendix 7.3** for the full set of criteria).

Stakeholder perspectives on processes for forming local teams

Project application evaluation criteria

A programme stakeholder shared the view that the 'suggested criteria for evaluators' lacked adequate specificity to evaluate applications fully and effectively. As a pilot programme, these criteria were necessarily developed without the benefit of prior programme implementation. Programme stakeholders have identified ways to develop criteria for future programmes, based on

learning from implementation of the pilot programme. For example, for project teams to require specific non-clinical expertise (such as QI and data expertise).

All teams that applied were selected to participate in the programme. It is therefore difficult to assess how the criteria were applied in team selection processes.

Project team perspectives

- **Project teams described notable variation in how local teams were formed.** In some cases, the lead applicant who completed the EOI and full application ended up being the project lead, and thus led on team formation. Where this was the case, project stakeholders reported feeling clear on what the LAN programme was, what was required of teams, and what would represent an appropriate and effective project team.

*“It was really clear in the application stage and also from the initial meetings that we had about the accountability, what was required of us as well.” **Project team lead and applicant***

- In other cases, **senior leaders pushed forward applications, without the knowledge or input of ultimate team members**, including those tasked with forming project teams. This meant that some project team members reported having very little information on the programme and what was required to build an effective team.

“We were thinking, ‘well, what could this be? Who should our team be?’ Because at that point you didn't really have much idea. More information would have been helpful right at the start.”

Project team member

- **Team members brought onto project teams after project commencement (in some cases several months after) faced challenges with not having the required knowledge or technical skills to implement an anti-racism QI, and lack of project ownership and buy-in.** Team members joining the programme later in the process missed earlier LAN education sessions and there were no ‘catch-up’ sessions available to bring them up to speed. This impacted their ability to contribute fully to the LAN QI project. Joining QI projects later also impacted sense of project ownership, buy-in, and subsequent engagement.

*It's really hard to get buy in on something you've already chosen [a project focus]. Choosing needs to be the whole team together, not that you choose and then we're expected to buy in. So actually that needed to be joined up. **Project team member***

- Based on information available to the evaluation team, **many team members detailed in project applications were not involved in QI project delivery.** The reasons for this are not fully clear, however teams did identify staff turnover as a challenge to consistent team membership. Some team members highlighted more information at the earliest stage would have been welcome to help determine feasibility, and to start project planning including recruiting appropriate project teams.
- **Team engagement with the LAN was variable due to clinical commitments and team changes.** Team changes are unavoidable and beyond the LAN's control. However, the extent to which this challenge was cited across project teams might suggest that initial team selection methods didn't result in groups that could fully and consistently meet the programme's demands.

Project team composition

Team composition varied across the cohort. In some cases, team composition was deemed appropriate to enable effective delivery of QI projects. However, some teams reported a lack

of involvement from members with requisite skills and experience, which impacted project delivery.

Across teams, the inclusion of certain roles and expertise was found to be a **significant enabler to project implementation**. This included:

- **Clinical representation reflecting the project's clinical focus, including senior clinical leaders.** Some teams secured representation as part of core project teams, and/or through ad hoc support from clinicians within their organisations. Some teams reported challenges due to a lack of representation from specific clinical groups, notably obstetricians and anaesthetists. These specialists were difficult to engage due to their busy clinical schedules.
- **Dedicated QI expertise.** Teams including dedicated QI expertise highlighted this as a core component of successful project implementation, which provided a springboard to engage with technical aspects of the model for improvement. The non-clinical nature of this role was also understood to help teams retain focus and momentum in project delivery, due to more flexible work schedules.
- **Data expertise** was a significant enabler to efficient project design and delivery. Dedicated expert support with data capture, cleaning, and analysis eased the burden on other team members, particularly busy clinicians, and improved related outputs.

"Having that data person worked really well, and it takes the pressure off the frontline team as well."
Project team member

- **Teams with active senior leadership engagement** felt this to be an important enabler for project implementation, helping to raise project awareness, profile, buy-in and support from senior leaders. Some teams struggled to achieve relevant leadership engagement, buy-in and support from senior leaders, which was felt to present significant challenges to project implementation. This was particularly the case with teams working across organisational boundaries.

"In hindsight for this kind of work where there are very specific interventions, change ideas that someone has to implement, we need very clear leadership, clear accountability structures and we need someone to own the work that.. can go and implement things." **Programme stakeholder**

- **Dedicated non-clinical project management support.** Non-clinical team members were understood to have greater flexibility with schedules compared to fixed-rota clinicians, which helped with LAN engagement. Examples were shared by teams where non-clinical team members provided highly effective dedicated project management. Teams without non-clinical representation found project management and administration fell to already very busy clinicians.
- **Public and patient involvement and engagement (PPIE) was a critical aspect of successful project teams, however the extent of PPIE varied significantly across project teams.** See section 'Public and patient involvement and engagement' below for further detail.

Beyond the core project team membership, some teams **engaged existing organisational support highly effectively**. Examples of this included support from organisational development teams in designing and delivering staff focus groups, research team support for patient recruitment and ensuring appropriate safeguarding approaches, trauma-informed experts, data experts, QI experts, and translation support.

Team ethnic composition

The ethnic composition of teams varied. Some were predominantly constituted of global majority ethnicities, whereas others were wholly or predominantly White British. Programme stakeholders and project teams highlighted the importance of having team members from local global majority communities for delivering an effective anti-racism focused QI project.

Teams with an ethnic composition that did not reflect the ethnicity of local populations described receiving support from global majority colleagues within their organisation, for example with patient engagement as part of the three-part data review. However, this support was not continuous throughout the QI project lifespan.

Project footprint

At the outset, programme stakeholders understood teams embedded within established systems—such as LMNS and ICBs—would provide the most effective team structure and related project infrastructure. However, this rationale was not represented in formal team selection criterion. In hindsight, this rationale has been questioned by programme stakeholders. Instead, programme stakeholders suggest teams and projects representing a maternity unit would be the most appropriate and feasible level of focus.

“In hindsight, that decision wasn't necessarily in the best interest of the project because we diluted ownership and leadership of this initiative, and the initiative is one that has to be delivered through a delivery unit, so someone has to be accountable.” **Programme stakeholder**

Project team perspectives support the view that teams sitting within overarching system management functions, such as Local Maternity and Neonatal Systems (LMNS) or ICBs, can be removed from frontline workers and lack a mandate to gain buy-in and accountability from intended organisational partners.

There were challenges for projects taking a system-level approach when the cross organisational collaborations were newly formed specifically for the programme. Challenges centred around fostering effective collaboration to implement change ideas across organisations, and accessing data across organisational boundaries. However, where effective ways of working already existed, evidence suggests that system-level teams can function effectively.

“We wouldn't have done it another way. We're very used to working across the system, so it wasn't a consideration for us.” **Project team member**

Public and Patient Involvement and Engagement

Approaches to patient and lived experience partner engagement varied across the cohort, often depending on local infrastructure and resource availability. Engagement with people with lived experience was largely isolated to interviews during the three-part data review phase. However, several project teams demonstrated more meaningful approaches to involvement:

- One project team kept patients engaged through three-part data review informed of project progress via email and invited them to an in-person LAN event. Another team conducted a multi-stakeholder workshop including patients to help co-produce the project approach.
- One project team fully embedded a lived experience partner with defined roles and responsibilities. The partner was fully compensated for their involvement, including childcare costs to enable their continued and active engagement. This was enabled by an existing organisational culture of, and commitment to, PPIE.
- Another team successfully identified resources to compensate partners, engaging them at specific, strategic intervals throughout the project.

- A lack of dedicated PPIE funds and infrastructure (policies, payment processes) remains a critical barrier, preventing some Trusts from compensating and effectively involving lived experience partners.

Recommendations for programme implementers

1. Mandate evidence of organisational readiness to support implementation of anti-racism QI within application forms and corresponding evaluation criteria.

- This should include, but not be restricted to, active senior level support, cultures that actively enable QI and anti-racism initiatives, and the provision of infrastructure required to implement projects effectively (including active PPIE).

2. As part of the application process and before selection to the programme, require project teams to secure dedicated (and protected) time and/or resource for essential project team roles.

- Specifically, this should include data experts, QI specialists, and non-clinical project management, alongside clinical leads.
- Criteria should include reference to ethnic diversity that reflects ethnic groups experiencing poorer health outcomes (i.e., populations of focus).

3. Improve team onboarding processes by providing greater clarity on programme and project commitments. This should include realistic time and resource requirements being communicated to all team members prior to the start of the programme. communicated directly to prospective team members prior to programme commencement.

- Implement a structured onboarding process for members joining after the project start to ensure alignment and ownership.

4. Enable improved and consistent PPIE across projects by providing additional resource for teams without adequate organisational provision.

- Require (or provide) specific budget allocations for compensating lived experience partners, including expenses for childcare and travel.
- Encourage teams to move beyond ad-hoc consultation by embedding lived experience partners into the core team structure with defined roles.
- *Whilst the intention is for teams to generate feasible low-cost interventions, the risk of not involving PPIE in change idea design and testing risks scaling ill-informed practices that may unintentionally exacerbate inequalities.*

5.4. QI project selection

Summary of findings

- Project selection was framed by the programme's four predefined clinical areas focused on morbidity. Some teams found these highly relevant to local needs, while others found them restrictive, forcing them to ignore higher-priority local issues.
- The programme utilised a structured three-part data review to inform project design and delivery. Most teams saw the approach as acceptable, however feasibility was challenged due to the process being time intensive and requiring specialist input.

Problem/project identification process overview

QI project selection was primarily guided by the programme's four clinical areas (post-partum haemorrhage, gestational diabetes, perinatal mental health, and pre-term birth).

After selecting a clinical area of focus for their project, QI teams were guided to begin with a structured three-part data review to refine their QI project aims and identify actionable equity gaps. This comprised:

1. **Quantitative review:** Analysis of existing data on maternal and neonatal outcomes for a selected sub-population (in the case of the LAN sub-populations represented minoritised ethnic groups experiencing poorer health outcomes);
2. **Professional perspectives:** Interviews with 2-5 care providers and relevant external partners;
3. **Lived experience perspectives:** Interviews with up to 10 individuals from the target population to understand their experiences and perceived inequalities.

This mixed methods approach was intended to ensure that projects were grounded in both quantitative data and lived experience. Instruction on undertaking the three-part data review was given in LAN sessions, and relevant templates were provided to help guide and structure the review.

How effective and appropriate were the processes for selecting teams/sites?

Overall, the processes for identifying local projects led to projects that were appropriate, important, and relevant to some local teams.

Programme clinical focus areas

- The selection and refinement of clinical focus areas was shaped by a range of strategic and practical considerations. Given the limited timeframe of the LAN, clinical focus centred on addressing morbidity rather than mortality and within areas they considered to be the most impactful and feasible. Prioritisation of appropriate clinical focus areas was informed by [MBRRACE-UK](#) reports, expert input from the NHS Race and Health Observatory (RHO) expert advisory group, and local data, leading to topics that spanned the perinatal period.
- Project team clinical focus was therefore framed by the programme's four chosen clinical areas. Stakeholder views on the appropriateness of the four clinical areas varied. While some teams considered the four clinical areas 'highly appropriate' and relevant to the maternal and neonatal health priorities of respective local systems, a few teams found predefined areas restrictive which diverted projects away from higher priority areas locally that presented more feasible options.

"It felt very restrictive, there were other things we could have considered." **Project team member**

Three-part data review

- The three-part data review served as the core mechanism for guiding decision-making related to project focus area, and projects' specific design. As outlined in **Section 5.2**, most teams saw the approach as acceptable and broadly feasible to support project selection and design, however there were feasibility challenges for some teams.
- Some teams highlighted the sequencing of the three-part data Review within the wider programme timeline as problematic. Some teams felt they had to identify a project focus area at the first in-person event, prior to the deep-dive data review. In some cases, findings from data review revealed that chosen topics were of lower priority or involved patient numbers that were too small to measure effectively.

"We had to make a snap judgement about what to focus on." **Project team member**

- Some teams revised their aims and focus areas several times after projects had commenced. This iteration, while analytically valuable, consumed critical project time, disrupted team morale, and led some stakeholders to question the validity of decisions made under time pressure. Feedback suggests that enabling teams to conduct baseline data reviews prior to the first session would have significantly improved the efficiency and validity of the project design process.

Other contextual factors influenced project choice. For example, in one instance initial project selection was over-ridden by a senior leader. This decision was understood to result in a less feasible project, and undermined project team confidence.

To what extent do the selected problems/projects align with the programme's goals, including having an effective anti-racism focus?

QI projects aligned with the programme's four clinical focus areas and anti-racism focus. The ability of projects to deliver programme goals was underpinned by effectiveness of project implementation, which varied across the cohort depending on contextual factors relating to the QI project team and local system characteristics.

- All ten projects were based on one of the four clinical focus areas and had an explicit anti-racism focus, incorporating an aim statement and population of focus that purposefully targeted racially minoritised group(s) experiencing worse health outcomes.
- Most projects were able to identify and apply relevant interventions/change ideas related to the programme's clinical areas and anti-racism principles, which were intended to contribute to change packages for spread and scale. The extent to which change ideas were implemented as intended varied across and within teams depending on contextual factors (see **Section 5.6**).

Recommendations for programme implementers

1. To ensure project selection and design is informed by robust assessment of relevant data and reflects local priorities, ensure baseline data review is completed before project selection.

- Teams should build in appropriate time to allow for an iterative process of data review to inform project selection.
- To support buy-in and accountability, encourage teams to co-produce projects with relevant microsystem and organisational level stakeholders, including clinical and senior leaders, and data experts.
- A co-production approach to project selection and design should improve multi-stakeholder buy-in, support and accountability, and reduce potential for senior leaders over-riding project-team decision-making.

2. Introduce flexibility in prescribed clinical focus areas so that QI projects align directly with baseline data and local priorities.

- Projects should align with local priorities as well as with programme aims, particularly given the resource inputs required for anti-racism QI project implementation.
- Greater alignment with local priorities should maximise project acceptability and feasibility, optimise chances for organisational support for successful project implementation, and ultimately increase likelihood of achieving programme objectives related to clinical outcomes and assessing anti-racism QI approaches.

3. Encourage organisations to allocate appropriate resource (financial and technical expertise) to deliver robust three-part data reviews to inform decision making.

- Effective and thorough three-part data reviews are essential to ensure projects are appropriately targeted and designed.
- Data-informed and intentional project design and implementation is essential to ensure projects tackle inequity in clinical outcomes and patient experience, and to avoid unintentionally exacerbating existing, or creating new, inequalities.

5.5. Programme training, development and support

Summary of findings

- The training and support package was widely praised for its high quality and relevance. The effectiveness of the offer was constrained to some extent by logistical challenges, and a steep learning curve for those new to QI.
- The programme schedule presented barriers to full engagement, and most teams found attending all pre-set sessions unfeasible.
- Views regarding the level of support for the emotional demands of the work were mixed. While some felt the programme successfully built psychological safety required for the sensitive nature of working through an anti-racism lens, others felt at times psychological safety within the LAN cohort was compromised.

The LAN programme provided comprehensive training and support to project teams, including:

- **Monthly QI coaching calls** for each team staffed by an expert advisor
- **Monthly All Teams online calls**, covering topics pertinent to the stage of QI project delivery
- **Targeted webinars:** Five anti-racism webinars and one clinical webinar
- **Four in-person Learning Sessions**, which included educational sessions and opportunities for project teams to present to one another and share learning

Has the training, development and support led project teams to feel equipped to implement anti-racism focused QI in their local services?

The training, development, and support package for project teams was largely praised by project teams, who saw the content and delivery as high-quality and aligned to programme aims. The effectiveness of the offer was constrained to some extent by logistical challenges, and a steep learning curve for those new to quality improvement (QI).

De-biasing and Anti-Racism

Sessions focused on de-biasing healthcare and understanding institutional racism were highlighted as particularly helpful and directly relevant to project delivery. This content, combined with the time and space for reflection and discussions, was felt to be a valuable part of the LAN by several team members.

While discussions on cultural sensitivity and unconscious bias were useful, some project team members felt they would have benefited from being delivered via formal training rather than discussion formats, which could have developed learning further. A few project team members suggested more detail on the origins of institutional racism would have provided further useful context on the nature of existing issues.

QI Methodology

Most participants found the technical QI training appropriate and 'pitched at the right level' for those new to QI. The focus on implementing projects in actionable steps, run charts, and data analysis was well-received, with some teams reporting that the content equipped them well for project delivery.

*We found that really supportive, to use very clear actionable steps using implementation structures to achieve the outcomes. So we would be, so they taught us about different methodology on why for example run charts work, how to act, look at our data. So that's really, really helpful. **Project team member***

- For those without prior QI experience, the learning curve was described as "steep." Some team members reported that the programme required a lot of 'learning while doing', which presented additional challenges for busy clinicians, and for teams without dedicated QI membership or support. Some project teams emphasised the importance of having a team member with dedicated QI expertise in overcoming these challenges and building and sustaining momentum with project delivery.
- Stakeholders suggested that future iterations of the LAN should include a skills audit during the application stage and based on this audit, offer asynchronous pre-programme learning modules to help team members enhance requisite skills and knowledge before the programme begins.

Structure and delivery of education and support

Project team members praised the programme's approach to education and support. Structured education equipped teams with relevant skills and awareness, and the programme provided valuable space for reflection on personal biases and cultural awareness.

- Group sharing sessions were identified as a high-value component. These environments allowed participants to share experiences, challenge each other and identify solutions to shared challenges.

*We touched base with other teams and realised that we weren't the only ones that felt the way we were feeling. So for me the most beneficial thing was just sharing the learning because we were all very similar. **Project team member***

- Coaching calls were generally well received by teams. They helped teams retain project focus, overcome implementation challenges, and maintain team motivation. Some teams reported that coaching calls could have 'stretched' the team more to achieve greater progress and rigour with project implementation, and to ensure continued focus on anti-racism as a primary project lens. In some cases, multiple changes in assigned coaches affected continuity and understanding of project context.

*"We had monthly coaching sessions which were really helpful, because she helped ground us again and go, 'It's OK, this is because you're dealing with this.' It helped keep us on track." **Project team member***

Feasibility challenges

Despite content being regarded as high quality and relevant, the programme schedule presented barriers to full engagement, and most teams found attending all pre-set sessions unfeasible. One team reported that the schedule was 'really intense' and sessions were more frequent than had been anticipated.

*Sometimes we were meeting every fortnight which is a lot. I thought maybe we'd be meeting every month or every two months. Between the coaching calls and other calls, all the stuff was really useful and really helpful, but it was very, very intense. **Project team member***

Some larger teams were able to secure representation at most sessions due to the inherent flexibility of a larger team. Teams that included non-clinical members had more flexibility to have team representation at sessions.

The timing of online educational sessions towards the end of the UK working day made it difficult to fully engage with the content. Some team members reported certain regular sessions overlapping with regular clinical duties, making attendance unfeasible.

While valuable, attendance at in-person events varied. The cost and time implications (up to three days off work) were challenging, particularly for geographically dispersed teams. Unequal access to travel funding meant some team members paid out of pocket. Given teams can be spread across England, some suggested a fixed, central location to all teams may improve overall accessibility.

Psychological safety

Views regarding the level of support for the emotional demands of the work were mixed. While some felt the programme successfully built psychological safety required for the sensitive nature of working through an anti-racism lens, others felt at times that psychological safety within the LAN cohort was compromised by a lack of clear programme guidelines for participating teams.

Teams emphasised that delivering anti-racism projects can be triggering, particularly for participants from the global majority and in the face of institutional resistance, and appropriate support structures need to be established from the outset.

*There needs to be kind of some preparation for the people who are taking this on.... it's been really difficult to be honest. **Project team member***

Recommendations for programme implementers

- 1. Prior to the start of the programme, conduct a skills audit of programme team members to assess existing levels of QI and other related knowledge.**
 - Based on results of the skills audit, construct pre-programme learning in the form of asynchronous learning modules to flatten the QI learning curve prior to programme start.
 - As appropriate, amend the in-programme education and support approach based on results from the skills audit.

- 2. Provide a more thorough psychological support structure from the programme outset.**
 - Design and implement support structures (e.g., resilience training and/or counselling access) to manage the emotional toll of anti-racism work.
 - Co-produce a set of clear and accessible guiding principles for psychological safety, to be upheld throughout the programme duration. Communicate these clearly at the programme's outset, and to any new programme participants joining thereafter.
 - Co-produce accountability and governance mechanisms to ensure guiding principles for psychological safety are upheld appropriately.

3. Improve programme accessibility of programme education and support.

- Reduce the frequency of synchronous meetings, transferring educational modules to an asynchronous format that can be accessed independently and completed at suitable times.
- Consider where in-person events can be held most accessibly and equitably given the geographical spread of teams. This might represent a consistent location equally accessible to all teams.
- Provide a centralised travel fund to prevent staff from paying out of pocket to attend important in-person programme events.

4. Ensure consistency and rigour of approach across all coaches, balancing constructive feedback with motivational communication.

- Instruct coaches to "stretch" teams further, ensuring they maintain a rigorous focus on the anti-racism lens throughout the project lifecycle.

5.6. Project implementation

Summary of findings

- The extent to which QI projects were implemented as designed and intended varied significantly across the project groups.
- Project teams reported a series of enablers and barriers to QI project implementation.
 - **Key enablers included:** appropriate multi-disciplinary teams (including clinical representation, data, QI and anti-racism expertise, project management support and senior leadership), access to quality disaggregated data on ethnicity, supportive organisations with existing cultures QI and/or anti-racism, access to resources for change idea implementation, and appropriate resources for PPIE.
 - **Key barriers included:** poor access to quality disaggregated ethnicity data, working in complex and longer-term pathways, challenges with cross-organisational working, QI project team and broader workforce capacity and time constraints, staff turnover, institutional racism, and lack of adequate resourcing for project implementation.

The evaluation sought to understand the contextual barriers and enablers to project implementation. To support and structure this, the evaluation team adopted the MUSIQ-AR framework, explained in **Section 4.2**.

This section outlines the key enablers and barriers to QI project implementation. Insights are framed using four of the five MUSIQ-AR domains: QI project, infrastructure, organisation, and external domains. Insights relating to the microsystem domain were relatively few and have been grouped primarily into the organisational domain.

Insights for each of the four domains are presented in turn, highlighting both the enablers and barriers to project implementation. Insights gathered from individual teams have been grouped together to give an overarching sense of the types of enablers and barriers QI projects working with an anti-racism focus might face. Therefore, not all factors highlighted here were experienced by all project teams.

Quality Improvement Project Factors

Enablers

Project team

- **Multi-disciplinary teams** (MDTs) - including quality improvement (QI), data, project management, anti-racism expertise, and relevant clinical representation - were well equipped to deliver QI projects as intended. MDTs also had greater resilience to contextual challenges, such as clinical capacity constraints and delivery of technical aspects of QI.
- **Ethnically diverse teams**, particularly where team membership reflects patient populations, was an important enabler to project implementation from start to finish by providing increased levels of cultural competency, trauma awareness, and lived experience insight. In particular, teams highlighted the importance of ethnic diversity in engaging staff and patients from the global south and having open and trusted conversations.
- **Dedicated and motivational team leadership** helped drive projects forward by providing clear project management, and identifying clear roles, responsibilities and accountability.
- **Culture of collaboration and teamwork** helped maintain focus, enthusiasm, and support to deliver complex projects within challenging contexts.

We met without fail every single week for 45 minutes. We weren't always all able to attend, but those who could did and every single week we were reviewing our data. That was so important to know exactly where we were at.

Project team member

Project scope

- **Projects operating within scope of control** - i.e., within environments where team members can engage and influence people and things to bring about a desired change - were more readily able to gain the buy-in and support from relevant stakeholders, including clinical specialists, data providers, senior leaders and front-line staff. Typically, these were projects working within a distinct microsystem.

Barriers/challenges

Project team

- **Building effective MDTs was a challenge for some teams.** Having no dedicated data expertise, QI expertise, and/or senior level support impacted on the feasibility of project implementation by making certain tasks more difficult and time consuming (e.g., data analysis) and reducing the level of organisation and microsystem support.

None of us are data experts. It would have been really useful to have somebody that could have had that data and done a real deep dive into it. That's been quite arduous. **Project team member**

- **Project team continuity and engagement.** Staff turnover made building and sustaining project implementation challenging in some cases. Some team members felt a lack of ownership and buy-in due to not being involved in project application, design, and early implementation stages.
- **Limited team capacity** due to workforce pressures, particularly for clinical team members with fixed schedules.

Project focus

- **Sensitivities of working through an anti-racism lens** requires appropriate expertise and experience (e.g., trauma-informed approaches) and psychological safety and support. This can add to the overall workload and complexity of a project.
- **Projects involving complex and/or longer-term pathways** such as pre-term birth and mental health, often involving working across organisations, presented complexity and challenges to collaboration and project implementation. A lack of mandate across organisations can make influencing change very challenging.

"We didn't have direct levers to make change happen on the ground." **Project team member**

Infrastructure Factors

Enablers

- **Access to ethnicity disaggregated data.** Teams able to readily and efficiently access ethnicity disaggregated data, for example through existing health inequality dashboards, could more quickly identify relevant clinical focus areas, populations of focus, and set appropriate project metrics.
- **Data expertise** was a significant enabler to efficient project design and delivery. Dedicated expert support with data capture, cleaning, and analysis eased the burden on other team members, particularly busy clinicians.
- **Patient and public Involvement and Engagement (PPIE)** proved an invaluable resource to teams. Given the sensitivities of working with an explicit anti-racism lens to de-bias existing maternity and neonatal care, PPIE involvement was critical to introduce and validate new approaches to care. Some organisations had strong cultures of PPIE, which provided an enabling environment whereby projects could secure dedicated and consistent PPIE.

Barriers/challenges

- **Poor data quality** of disaggregated ethnicity data. Some teams encountered significant gaps and outdated frameworks regarding ethnicity coding. Data access and quality varied across project teams.

"We knew certain people weren't represented in our data... Somali women weren't clearly visible." **Project team member**

- **Data access** presented a challenge for some teams, notably those working across multiple organisations. In some cases, requisite data could not be obtained due to organisational restrictions to data access.
- **Resource deficits** impacted project delivery. Many teams noted the challenges with dedicating time and effort to project delivery (and programme engagement) due to fixed and intensive clinical schedules and a lack of staff backfill. A lack of dedicated project funding also impacted the extent of PPIE and change idea implementation (e.g., no available funds to include additional clinic).

"For such an important project that is impacting a significant proportion of our maternity population, it's interesting that the NHS hadn't put any money behind it from an innovation perspective and it was all expected basically to be done on our own time. It would have been nice if a small sum of money went to trusts to either backfill the person's time to ensure that they were able to complete on the objectives." **Project team member**

Organisational and Microsystem Factors

Enablers

- **Tech expertise from non-core team members** provided some teams with highly valuable input and support (e.g., data analysts, organisational development, research, PPIE, translation).
- **Existing cultures of anti-racism** and cultural competency within organisations provided an enabling environment that supported project delivery by providing a shared language and increased levels of buy-in and support from frontline staff to senior leadership. E.g., Black Maternity Matters, a system-wide anti-racist programme combined with quality improvement project implementation for NHS perinatal teams, implemented in West of England region.
- **Commitments to Quality/Continuous Improvement** also enabled QI project delivery through organisational buy-in and support. This included provision of QI expertise (either full-time for the project or ad-hoc support), as well as broader organisational awareness of QI.

“Over the last 3½ years... members of staff... have either been through first steps in QI or have been through QI coaches.” **Project team member**

- **Senior level buy-in and support** can facilitate organisational-level buy-in and support for project implementation, including the release of funds for project delivery.

“The trust itself and the wider management team are very supportive here and I think that's a huge part to play in it because we have the ability just to get the ball rolling and immediately make a start on implementing it.”

Project team member

- **Frontline staff engagement and support, including clinician input (notably obstetricians).** Projects require the support and buy-in from a range of stakeholders to be effective in trialling new approaches. Projects that effectively engage frontline staff support, either directly and/or through leadership support, could more effectively implement projects.

Barriers/challenges

- **Changing culture and behaviours** presented challenges for teams, particularly where there was no existing culture of QI and/or senior leadership support. Operating in an anti-racism embedded QI space can be technically challenging and emotionally exhausting for teams.

“You're not just delivering a QI, you're changing people's narrative and perspective on something that they may not be willing to change or see a problem in. And that is hard on the individual trying to do that. We felt like we were hitting our heads against a brick wall when it came to senior leadership because that engagement just wasn't there.”

Project team member

- **Lack of anti-racism culture and/or cultural competency** made having discussions with project stakeholders – from frontline staff to senior leaders – very challenging for some teams. Perceptions of persistent institutional racism presented significant barriers to project delivery.
- **Competing priorities, including other QI projects,** impeded buy-in and support for projects. In one instance, an existing QI project focusing on the same clinical area (Post partum haemorrhage) was felt to undermine project support. Organisational priorities not aligned with project objectives also presents barriers to optimal project support and delivery.

External Factors

Enablers

- **LAN programme education and support** provided project teams with technical QI knowledge and support to implement anti-racism focused QI projects. This included knowledge, expertise, and support imparted through coaching calls, in-person and online sessions, and peer-learning forums.

"Having the in-person workshops... there was some really, really good learning." **Project team member**

"The policy workshop was a helpful roadmap to think through how we debias policies." **Project team member**

"It allowed for us to have very honest and frank discussions... in a safe space." **Project team member**

- **Race and Health Observatory (RHO) anti-racism principles** provided a valuable framework and approach for teams to guide anti-racism embedded QI projects, particularly around de-biasing policies, protocols, and practices.
- **RHO's profile** was cited as providing weight and importance to QI projects, in some cases helping to secure senior leadership buy-in and support.
- **High profile visits from NHS and government** can shine a spotlight on QI projects, emphasising their importance, objectives, and need, as well as open the door for increased support to facilitate project delivery.

Somebody from NHS England visited the hospital because of the work that we'd done and that made everything, 'oh, we have to take this very seriously'. So that also helped. The external visits to validate good work is a really powerful way of getting people to see that as important within their workspace. **Project team member**

- **Crisis event** in the form of a national blood shortage was understood to be a significant enabler for a QI project focusing on post-partum haemorrhage (PPH). The need to reduce utilisation of blood stocks increased willingness to adopt project interventions to limit the incidence and severity of PPH.

Barriers/challenges

- **Data access across organisations** was a notable barrier for teams operating across organisational boundaries. In some cases, requisite data could not be obtained due to organisational restrictions to data access.
- **System working** can be highly challenging for teams where an existing culture of system or cross-organisational working is not already in place. Challenges were faced due to a lack of collaboration and accountability, a lack of mandate to influence external stakeholders, and limited governance from system leadership.
- **NHS structure changes** particularly at the Integrated Care Board (ICB) level were felt by some teams to undermine support that had been previously agreed, impacting a project that required ICB level governance and support.

"We've had a real period of change. NHS England and ICBs have had massive changes. A big part of this project is the public health aspect, and those are the people who are pivotal in supporting that. So, it's made it difficult."

Project team member

- **Reduced national emphasis on equity, diversity, and inclusion (EDI)** was understood by one team to disrupt project alignment with system priorities, making it harder to engage relevant stakeholders for buy-in and support for system-level project delivery.

When we embarked on this programme, there was a very clear steer from NHS England that this mattered and it was a priority and I think we lost that by the end of the programme. **Project team member**

5.7. Project and programme outcomes

Summary of findings

Some projects effectively achieved goals related to debiasing protocols, staff empowerment and learning, and organisational cultural change.

A full picture of clinical outcomes cannot be provided because the evaluation did not analyse validated clinical data and due to the early stage of implementation, however positive impacts on morbidity:

- **Impact on morbidity:** one team reported making a positive impact on measures relating to post-partum haemorrhage resulting in parity across ethnicities.
- **Most teams continue to monitor and measure project outcomes,** and therefore it is too early to determine the efficacy of change ideas on intended clinical outcomes.

Due to the evaluation's methodologies and timeframe, it is difficult for the evaluation to make a clear, full, and definitive independent assessment on project and programme outcomes. From self-reported project-level outcomes, however, there are clear indications of progress relating to process and clinical outcomes.

The extent to which project teams have achieved progress within these areas seems to have varied significantly across the cohort, with some teams reporting low progress on process outcomes, whilst others report having made improvements in clinical morbidity outcomes.

It should be noted that data collection for this evaluation ceased in September 2025, and given that projects have continued to be delivered, further progress has been made that is not captured within this report. For certain projects, impact on maternal morbidity and mortality is inherently longer-term, and as such positive effects on clinical outcomes would not be expected within the timeframe of the LAN programme nor this evaluation.

Process level outcomes

Some projects appear to have been **effective in achieving progress on process-level outcomes**, which included explicit programme goals around de-biasing policies, protocols, and procedures.

- Several teams reported efforts to **de-bias existing protocols** (e.g., risk assessment forms and protocols). These changes have been taken up to varying degrees, with some reportedly representing business as usual.
- Other teams noted a **culture shift within broader organisations/trusts** stemming from project-related engagement with staff, notably with senior leaders. This shift has included a greater acknowledgement of health inequalities based on race and ethnicity.
- Several team members highlighted the **significant realisation and learning journey** they went through, related to technical areas of QI delivery, but more profoundly in how they will approach work in future aligned with an equity and anti-racism lens.
- Some team members felt **'empowered' by the programme to speak up** and seek to address these issues within their systems, including adopting an anti-racism approach to other maternity improvement work.

Clinical outcomes

While teams reported making changes at a process level, they had not yet had impact on clinical measures initially targeted within the LAN's timeframe. The evaluation did **not gather or analyse project-level clinical outcome data** and therefore cannot make a validated assessment.

- **One team reported making a positive impact on measures relating to post-partum haemorrhage** resulting in parity across ethnicities. Other teams are at a stage of measuring potential effects of their change ideas, and therefore it's too early to determine any implications for clinical outcomes.
- In the final stages of the programme, some teams had begun using run charts to track outcome measures directly relevant to their initial aims, while others were focussing on analysing process data, reflecting the relatively early stage of implementation.

5.8. Explanatory theory of an anti-racism focused QI approach

Introduction

This section proposes an explanatory theory describing how embedding anti-racism principles within a QI framework can drive equitable maternal and neonatal health outcomes. This theory draws on the experiences of the ten pilot teams, evaluation findings, and the application of the adapted MUSIQ-AR framework. It explains the mechanisms by which this approach shifts clinical practice, organisational culture, and ultimately, health equity.

The Core Premise

The programme operates on the premise that technical QI methodologies are necessary but not designed to tackle racial health disparities alone. Standard QI relies on data and process, but often overlooks the systemic biases and power dynamics that produce inequity.

By integrating the RHO's anti-racism principles into the Model for Improvement, the programme creates a dual mechanism for change:

1. **Technical Mechanism:** Using ethnicity disaggregated data to purposefully identify gaps, test changes, and measure impact relevant to improving health outcomes for racially minoritised groups who experience worse health outcomes
2. **Cultural Mechanism:** Using anti-racism principles to de-bias decision-making, challenge institutional norms, and collaborate directly with those from the global majority to co-produce approaches that directly reflect the voices and experiences of the global majority.

How the Approach Works: A Three-Stage Process

1. Foundation: Creating awareness and readiness for change

Successfully targeting and addressing institutional racism within healthcare begins with acknowledging institutional racism as a root cause of health disparities.

- **Mechanism:** Education on anti-racism approaches and "safe spaces" for reflection allow teams to move beyond "colour-blind" clinical approaches.
- **Action:** Teams engage in de-biasing sessions and collect and review local data disaggregated by ethnicity. This process evidences the existing disparities in their own services and provides initial direction for project design and implementation.

- **Key Enabler: Psychological Safety.** When staff feel safe to discuss race without fear of blame and/or (re-)traumatisation they can critically examine and actively challenge their own beliefs and practices, and those of others.
- **Output:** An actively anti-racism focused shift in mindset from "treating everyone the same" to "treating everyone equitably."

2. Design: Co-production and targeting

Once the problem is identified and understood, the QI methodology provides the structure to address it.

- **Mechanism:** The **three-part data review** triangulates quantitative data, professional insight, and **Lived Experience (PPIE)**. This process directly informs project design, including defining target populations, mission statement (measurable objectives), monitoring approaches (statistical process control charts) and ideation for plan, do, study, act cycles.
- **Action:** Teams co-produce interventions (change ideas) with project stakeholders, including relevant clinical staff and lived experience partners/patients.
- **Key Enabler: Representative Teams.** Ethnically diverse multi-disciplinary teams that include data experts, diverse clinical leads, and lived experience partners ensure interventions are delivered with appropriate culturally competency and clinically feasible.
- **Output:** Targeted "Change Ideas" (interventions) that specifically address the needs of minoritised groups, rather than generic improvements that might exacerbate inequalities.

3. Implementation: Testing and de-biasing

The delivery phase uses **Plan-Do-Study-Act (PDSA)** cycles to test and monitor change ideas in near-time.

- **Mechanism:** Iterative testing and monitoring intended change via appropriate metrics and data capture processes allows teams to see if interventions reduce bias in practice.
- **Action:** Teams implement changes (e.g., de-biased risk assessment tools) and track results using **statistical process control charts (SPC charts)**. Crucially, project teams continuously assess whether interventions are working as intended *for specific racially minoritised groups purposefully targeted through the QI project*.
- **Key Enabler: Organisational Buy-In.** Senior leadership support legitimises the work, unlocking resources and empowering frontline staff and clinical leadership to challenge existing discriminatory protocols and adopt changes in practice with fidelity to intended design.
- **Output: Process Outcomes** (de-biased policies, protocols and practice, staff empowerment and culture shifts) leading to **clinical outcomes** (parity in health metrics like PPH rates).

The Outcome Pathway

When these mechanisms function together, they produce a cascading effect:

1. **Individual Level:** Staff become conscious anti-racist practitioners actively spotting and disrupting institutional racism and racist bias in their daily interactions.
2. **Microsystem Level:** Local protocols (e.g., induction of labour guidelines) are rewritten to be racially equitable, and data is routinely monitored by ethnicity.
3. **System Level:** Successful pilots create "Change Packages"—proven blueprints that can be scaled to other trusts, influencing national policy.

Contextual Critical Success Factors

The evaluation highlights that this theory does not work in a vacuum. It relies on specific contextual conditions:

- **Data:** You cannot improve what you cannot measure. Reliable ethnicity disaggregated data at the local level is essential to identify and address areas of inequality effectively.
- **Time and resource:** Anti-racism work is emotionally and technically demanding. It cannot be done sustainably and at scale as an addition to existing 'business as usual'. It requires protected time and funding, knowledge and expertise, with the aim of becoming a core and uncompromising aspect of future ways of working i.e. new business as usual.

Leadership: Leaders must be willing to "name racism" explicitly and support staff when they challenge institutional racism. It is essential that organisational leaders instil active cultures of QI and anti-racism that create fertile enabling environments for this work to take root and develop.

6. Recommendations

This section provides an overview of recommendations to inform anti-racism focused Quality Improvement (QI) in maternity and neonatal services. Detail to support implementation, including recommended actions for QI teams, organisational leaders and programme conveners, is provided **Appendix 7.6**.

These recommendations were co-developed during a workshop with Learning and Action Network (LAN) stakeholders, including project team members (NHS staff), staff from the NHS Race and Health Observatory (RHO), Institute for Healthcare Improvement (IHI), UCLPartners (UCLP), and the Health Innovation Network (HIN) South London.

Following the stakeholder workshop, draft recommendations were synthesised by the evaluation team, and refined in discussion with evaluation advisory board members, including a [Race Equality Foundation](#)⁸ representative and a lived experience partner.

The recommendations are structured to address the evaluation findings from domains of the Model for Understanding Success in Quality - Anti-Racism (MUSIQ-AR): external environment, organisation, quality improvement (QI) project team and infrastructure. Evaluation findings relating to the microsystem were found to fit well with those from the organisation domain, and to streamline recommendation development were integrated into that domain.

⁸ The Race Equality Foundation (REF) is a national charity tackling racism in UK society.

Table 1 Co-developed recommendations for delivering anti-racism focused QI

MUSIQ-AR domain	Contextual factor	Audience	Recommendation
	External Environment	Cross-system working	Programme conveners, organisational and system leaders and QI teams
Anti-racism QI expertise and support		Programme conveners and QI teams	<p>QI teams should be provided with structured QI and anti-racism expertise and support as required to deliver projects effectively and safely. The RHO LAN would be ideally situated to provide this.</p> <p>Ensure QI project teams feel prepared before project delivery begins and support teams to assess anti-racism QI readiness, for example using MUSIQ-AR.</p> <p>Facilitate alignment of projects and collaborative learning across QI project teams where shared pathways exist, e.g., through change packages that can be adapted to the local context.</p>
Peer-peer networking		Programme conveners and QI teams	<p>Facilitate opportunities for QI project team peer-peer learning through structured, in-person interactions, while continuing to offer online options for accessibility.</p> <p>Provide funding to mitigate access barriers, e.g. for travel and childcare. Networking should be intentionally designed to bring together teams who do not normally work with each other, creating space for shared learning across different contexts.</p>
Impact of high-profile influence		Programme conveners and QI teams	<p>Increase project visibility, credibility, and profile to optimise opportunities for system- and organisational-level awareness, buy-in, and support through planning high-profile visits to QI project sites (e.g., from senior NHS England, RHO, and/or government officials).</p>
NHS structure changes		Programme conveners, organisational and system leaders	<p>Embed senior cross-system support across QI project governance and accountability structures to ensure continuity and resilience during periods of organisational change. Cross-system oversight will help maintain stability, provide a consistent point of escalation and ensure projects remain on track even when structures or responsibilities shift.</p>

Organisation	Anti-racism culture and initiatives	Organisational and system leaders	Organisations should conduct a structured assessment of their current anti-racism maturity, identify gaps, and develop a clear, time-bound action plan to embed anti-racist principles across policies, practices, and culture. This commitment should be visible, measurable, and supported by leadership accountability. Organisations may find the Race Equity Maturity Index , developed by the London Anti-Racism Collaboration for Health, helpful. Engage in cross-organisation sharing/learning.
	Organisational support for QI projects	Organisational and system leaders	<p>Organisational-level support for anti-racism focused QI projects should include dedicated technical expertise (e.g., data analysis, programme management, anti-racism and trauma-informed practice), financial resources, and access to specialist teams such as patient and public involvement (PPIE) and research.</p> <p>Organisations should embed these capabilities as core infrastructure for QI, ensuring equity of access across all sites and reducing variability in support. Consistent access to necessary resources may be secured by mobilising support from stakeholders across the system.</p>
QI Project Team	Team capability	Programme conveners, organisational and system leaders and QI teams	Strengthen capability within QI project teams, including around QI; data management, capture and infrastructure; and anti-racism, equity, diversity and inclusion. Make engaging, interactive training available on an ongoing basis. Provide debriefing and emotional support for project team members.
	Ethnic diversity within teams	Programme conveners, organisational and system leaders and QI teams	<p>Ensure project teams are intentionally diverse in ethnicity and lived experience. Establish clear criteria and transparent processes for team formation, including how and when members are selected.</p> <p>Provide structured support for all QI team members, recognising that individuals will be at different stages in their learning journey, and embed opportunities for reflection and development throughout the project lifecycle and beyond.</p>
	Lived experience partner involvement	Programme conveners, organisational and system leaders and QI teams	<p>Expand and embed the role of lived experience partners. Their involvement should go beyond consultation to active participation in shaping priorities, co-designing change ideas, and contributing to decision-making throughout the entire QI lifecycle.</p> <p>This includes ensuring lived experience partners have the resources, training, and support needed to influence project planning and delivery meaningfully, and that they are offered appropriate incentives for their time and expertise.</p>
	Project team capacity	Organisational and system leaders	<p>Provide dedicated project management and clinical staff resourcing for anti-racism focused QI projects to ensure delivery is sustainable and impactful. This should include allocating protected time for clinicians, embedding skilled project managers within teams, and providing access to specialist expertise (e.g., data analysis, equity and anti-racism).</p> <p>Adequate resourcing is critical to maintain momentum, reduce reliance on staff working beyond their core roles, and enable consistent progress across all phases of the QI lifecycle.</p>

Infrastructure	Local data access	Programme conveners, organisational and system leaders	<p>Strengthen efforts to ensure robust and equitable access to high-quality, disaggregated ethnicity data at both QI project and national levels. Baseline data collection should be prioritised and used to inform QI team selection, project design, and training.</p> <p>Comprehensive capacity building on data access and utilisation must be provided to all QI teams. At the national level, urgent action is needed to address systemic challenges such as lack of data standardisation, variations in data maturity, and interoperability issues.</p> <p>These improvements should be supported by clear governance, accountability frameworks, and sustained funding to guarantee consistency, comparability, and reliability across all anti-racism focused QI initiatives. The NHS England Ethnicity Recording Improvement Plan may support organisations.</p>
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7. Appendices

7.1. Appendix A. Evaluation aims and objectives

Aim 1: to understand the feasibility and acceptability of the approach

To evaluate the programme design and rationale

- Is there a clear statement of aims and objectives, shared by stakeholders?
- How well does the programme design align with the intended goals?
- Are the programme's underlying principles and mechanisms feasible and acceptable to stakeholders, including those with lived experience?
- Does the implementation of the programme align with the stated aims and objectives?
- During implementation, how and why, if at all, has the programme been adapted from the original design
- To what extent has the programme reached the intended audience?
- Is the programme an effective approach to achieve the intended (process and clinical) outcomes?

To evaluate the process of project team selection and formation

- How effective and appropriate were the processes for selecting teams/sites and forming local teams?
- Did these processes ensure adequate representation and inclusion of members who will be involved in and able to act on QI with embedded anti-racism principles?
- Do the teams have appropriate representation of relevant stakeholders, including those with lived experience?

To evaluate the problem/project identification for project teams

- Did the processes for identifying local problems/projects enable projects which are appropriate, important and relevant to the local teams?
- To what extent do the selected problems/projects align with the programme's goals, including having an effective anti-racism focus?

To evaluate the training, development and support for project team staff to carry out anti-racism focused QI

- Has the training, development and support for project teams been clear and relevant to their circumstances?
- Has the training, development and support led project teams to feel equipped to implement anti-racism focused QI in their local services?

To evaluate the implementation and early outcomes of local QI activities

- To what extent have teams been able to implement QI projects as designed?
- What enablers and barriers have been encountered in implementation?
- What evidence is there of progress towards intended outcomes (both process and clinical), as specified by the teams?

Aim 2: To inform scale and spread in subsequent phases of the programme

To develop an explanatory theory of how the anti-racism focused QI approach works

- Based on the analysis of the case studies, which will demonstrate how contextual factors have influenced the success of QI projects, to develop explanations of how and why the QI projects did or did not achieve their individual aims and the aims of the anti-racism focused QI programme.
- To derive from this theory some recommendations for future QI programmes of this kind.

To make recommendations for spread, scale and sustainability, including lessons learnt

- What factors influence the potential for spread, scale-up and sustainability of the programme?
- What adaptations or refinements could enhance its broader applicability and long-term impact?
- What lessons can be learnt from future program iterations and evaluation protocols?

7.2. Appendix B. MUSIQ-AR Domains and contextual factors

This Appendix shows the final version of the MUSIQ-AR domains and contextual factors, incorporating an anti-racism focus.

Domain: External Environment (outside of the organisation)
External motivators (project specific)
External motivators (QI&I)
External knowledge (project specific)
External knowledge (QI&I)
External project sponsorship
Additional contextual factor: External support for integrating an anti-racism approach within QI
Definition: The extent to which external organisation or experts support the project team to understand and apply an anti-racism approach within QI.
Additional contextual factor: Impact of structural racism
Definition: The extent to which structural racism (racism that is embedded within the fabric of society e.g. when rules, policies, and practices in society work together to disadvantage some racial groups over others) impacts the QI project progress and success.
<i>Understanding and acknowledging the impact of structural racism is one part of RHO principle 2.</i>

Domain: Organisation (e.g. the NHS Trust where the project is being conducted)
Organisational Leadership (project specific)
Organisational Leadership (QI&I)
Task Strategic Importance to Organisation
Organisational QI&I Maturity
Payment Structure (project specific)
Payment Structure (QI&I)
Organisational QI&I Culture
Additional contextual factor: The organisational leadership names racism
Definition: The extent to which the leadership of the organisation engages seriously and continuously with the ways in which racism impacts the lives of the patients and the public, and actively works to dismantle it.
<i>Aligns to RHO principle 1: Demonstrate leadership by naming racism</i>
Additional contextual factor: Proactive identification of racial bias
Definition: The extent to which there is an organisational culture of actively seeking to identify racial bias (unfair treatment or prejudice against individuals based on their race or ethnicity, including discrimination, stereotyping, and microaggressions), for example within policies and decision making.

Aligns to RHO principle 5: Identify racial bias

Domain: Infrastructure (e.g. resources for the project, availability of data)

Data available to guide project

Data infrastructure for QI&I

Resource availability (project specific)

Specialist QI&I staff

QI&I Workforce Focus

Managing QI&I Portfolio

Additional contextual factor: Availability and completeness of data on race and inequalities

Definition: The extent to which good quality data (data that is accurate, complete, consistent and up-to-date) on race is collected and available to inform and evaluate improvement work conducted through the lens of racial inequality.

Aligns to RHO principle 4 – Collect and publish data and RHO principle 7 – Evaluate and reflect

Domain: Microsystem (e.g. the maternity department / unit)

Microsystem Leadership (project specific)

Microsystem QI&I Leadership

Microsystem Capacity (project specific)

Microsystem QI&I Capability

Microsystem Culture

Microsystem QI&I Culture

Additional contextual factor: The microsystem (e.g. departmental / unit / practice) leadership names racism

Definition: The extent to which the leadership of the microsystem (i.e. the department, unit or practice where people from different professions come together to offer care to a particular population of patients) engages seriously and continuously with the ways in which racism impacts the lives of the patients and the public, and actively works to dismantle it.

Aligns to RHO principle 1: Demonstrate leadership by naming racism

Additional contextual factor: Identify racial bias

Definition: The extent to which the department / unit / practice actively seeks to identify racial bias (unfair treatment or prejudice against individuals based on their race or ethnicity, including discrimination, stereotyping, and microaggressions), for example within policies and decision making.

Aligns to RHO principle 5: Identify racial bias

Additional contextual factor: Race-critical lens

Definition: The extent to which the department / unit / practice applies a race-critical lens to other quality improvement projects and to the design and delivery of services

Aligns to RHO principle 6: Apply a race-critical lens

Domain: QI&I Team (the people directly involved in planning and delivering the QI project – staff and PPIE)

Prior QI&I Experience

Team Diversity

Physician and Clinician Involvement

Patient Engagement and Involvement

Team Leadership

Decision Making Processes

Team Norms

QI&I Skill

Team Tenure

Subject Matter Expert

Additional contextual factor: Meaningfully involve racially minoritised staff

Definition: The extent to which racially minoritised staff are meaningfully involved in every stage of the QI project, including in decision making for the project

Aligns to RHO principle 3, meaningfully involve racially minoritised individuals & communities

Additional contextual factor: Meaningfully involve racially minoritised people who have lived experience

Definition: The extent to which racially minoritised people with relevant lived experience are meaningfully involved in every stage of the QI project, including in decision making for the project

Aligns to RHO principle 3, meaningfully involve racially minoritised individuals & communities

7.3. Appendix C. RHO LAN Quality Improvement project selection criteria

Main Criteria	Specific Elements	Guiding Questions	Score	Comments
POTENTIAL FOR IMPACT	High need / opportunity	<ul style="list-style-type: none"> Does the application demonstrate a high opportunity to reduce clinically avoidable severe maternal morbidity and improve the experience of care of non-white birthing persons? If data has been submitted, does the maternity unit have a high rate of maternal morbidity, particularly in non-white ethnicities? How many births per year occur at this maternity unit? (higher volume can mean more potential for impact and higher probability to see improvement in 7-15 month period) 	1 – 5	
	Scope of control	<ul style="list-style-type: none"> In evaluator’s opinion, are the greatest maternal morbidity challenges highlighted in Question 4 in the team’s gift to affect within a 7-15 month period? Can the stated maternal morbidity challenges be addressed through more reliable implementation of evidence-based standard clinical processes? 	1 – 5	
	Client base	<ul style="list-style-type: none"> Are users of applicant’s maternity services ethnically diverse? 	1 – 5	
COMMITMENT TO ANTI-RACISM	Demonstrated commitment to anti-racism	<ul style="list-style-type: none"> How committed is the service to anti-racism? Are there other initiatives or investments to address maternal health inequalities? 	1 – 5	
ORGANIZATIONAL READINESS	Goals for participation	<ul style="list-style-type: none"> Does the applicant have a specific goal to address maternal mortality and morbidity? Does the applicant have any other QI projects running in the maternity unit? 	1 – 5	
	Team composition and capacity / capability	<ul style="list-style-type: none"> Does the applicant list a leader senior enough to be an effective senior sponsor (removing obstacles/providing resources)? Has the applicant included project team members who are well-suited to the project and represent relevant disciplines? Does the applicant have existing projects addressing maternal care? 	1 – 5	
	Data capability	<ul style="list-style-type: none"> Does the proposal include any quantitative baseline data? Is data available to stratify and analyze by ethnicity? 	1 – 5	

7.4. Appendix D. LAN Programme driver diagram (Draft)

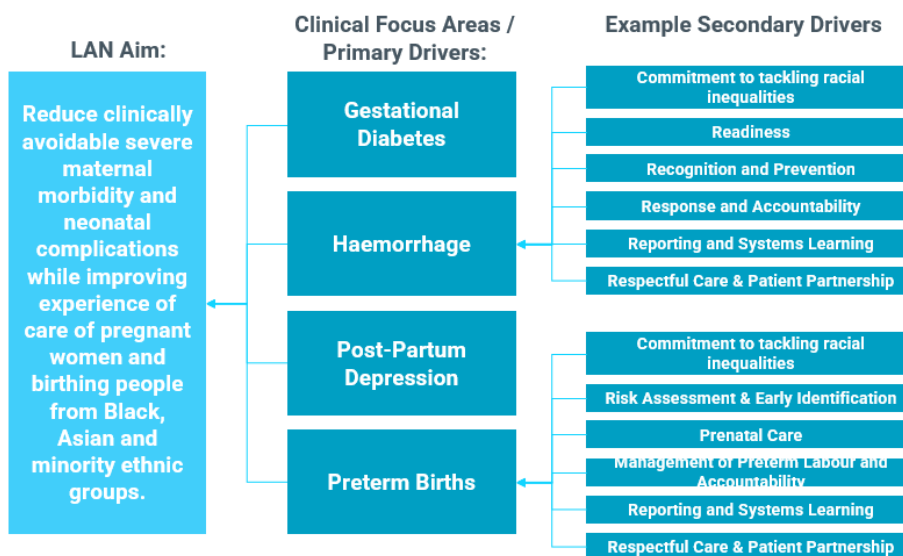
Draft Driver Diagram focused on key clinical areas:

Reducing ethnic & racial inequities across continuum of prenatal, perinatal, and postnatal maternal care + neonatal care based on team applications, MBRRACE-UK report, and what's achievable in LAN



Example Secondary Drivers

Each Clinical Focus Area will have a corresponding Change Package for teams (see example Haemorrhage Change Package), which will include specific change ideas for teams to use and test



7.5. Appendix E. QI project team focus areas

Team	Change package	Objectives
Barts Health NHS Trust	Post-partum haemorrhage	To reduce the number of elective PPH incidences for British Bengali Women at Barts Health by 20% by December 2024 and 50% by June 2025.
Birmingham Women's and Children's NHS Foundation Trust	Post-partum haemorrhage	To initiate an education package to improve the outcomes of Black and Asian women and birthing people who have a PPH, with a targeted focus on Black African Ethnicities. Bringing this down to a gradual reduction of 1% per year by 2027.
NHS Bristol, North Somerset and South Gloucestershire ICB (BNSSG)	Preterm birth	To increase antenatal steroid and magnesium sulphate administration in the population racialised as Black at risk of pre-term birth within BNSSG by March 2025.
East London NHS Foundation Trust (ELFT)	Maternal mental health	Increase access for Black African, Black Caribbean and Mixed White/ Black African and Caribbean women to ELFT Perinatal Services by 10% by March 2025. To use anti racist approaches and improve patient experience
Imperial College Healthcare NHS Trust	Post-partum haemorrhage	To achieve parity in PPH rates in all ethnicities in 12 months
Lancashire Teaching Hospitals NHS Foundation Trust	Post-partum haemorrhage	Reduce post-partum haemorrhage (≥ 1000 mls) experienced by Black & minority ethnic women & birthing people by 50% (from 12% to 6%) by 01.03.25
Manchester University NHS Foundation Trust	Gestational diabetes	By December 2024, increase the number of South Asian women with gestational diabetes who are aware of and access postnatal diabetes follow-up and screening, including referral to diabetes prevention support.
Northern Care Alliance NHS Foundation Trust	Gestational diabetes	To reduce the proportion of South Asian Women with Gestational Diabetes at NCA on diet control moving to metformin and/or insulin to 30% by March 2025.
North Central London (Royal Free London NHS Foundation Trust)	Maternal mental health	Improve detection of perinatal mental health problems amongst Black women and birthing people living in N15 and N17 postcodes in North Central London.
University Hospitals of Leicester NHS Trust	Maternal mental health	To increase referral of South Asian women in Leicester City to antenatal perinatal mental health services by 10% by June 2025.

7.6. **Appendix F.** Co-developed recommendations

Creation of recommendations

This Appendix outlines a set of practical and actionable recommendations to inform anti-racism focused QI in maternity and neonatal services, based on the evaluation findings. These recommendations were co-developed with Learning and Action Network (LAN) stakeholders, including QI project team members, staff from the NHS Race and Health Observatory (RHO), Institute for Healthcare Improvement (IHI), UCLPartners (UCLP), and the Health Innovation Network (HIN) South London.

Following presentation of the evaluation findings during a workshop held in November 2025, LAN stakeholders worked in mixed groups to draft recommendations. These draft recommendations were synthesised by the evaluation team and further discussed and refined with members of the evaluation advisory board, including a representative of the Race Equality Foundation and a lived experience partner.

The recommendations are structured to address the evaluation findings from domains of the Model for Understanding Success in Quality - Anti-Racism (MUSIQ-AR): external environment, organisation, quality improvement (QI) project team and infrastructure. Evaluation findings on the microsystem were found to fit well with those from the organisation domain, and to streamline recommendation development were integrated into that domain.

We intend that the recommendations will inform future practice for conducting anti-racism focused QI in maternity and neonatal services. To support implementation, the evaluation findings, recommendations, and associated audiences and actions are outlined.

The NHS Race and Health Observatory have indicated that they may undertake work to prioritise, share and support implementation of these recommendations.

Defining the audiences

The different audiences for the recommendations and actions are defined in the boxes that follow. To support easy navigation, these boxes are colour-coded by intended audience. Actions for organisational and system leadership are presented together because there is frequent overlap between the two, and many actions require a cross-organisation approach. This also reflects the fact that some LAN QI teams operated across local healthcare systems rather than within individual provider trusts.

QI team

The group responsible for planning and implementing anti-racism focused quality improvement.

Organisational leadership

Leaders of an organisation where anti-racism focused quality improvement work will be or is being implemented, for example leaders of NHS Trusts.

System leadership

Leaders who bring together people, organisations and work plans across a health and care system, not just within individual organisations.

System leaders for maternity and neonatal services may include people working in Integrated Care Boards (ICBs) and Local Maternity and Neonatal Systems (LMNS).

Programme conveners

Individuals and organisations responsible for co-ordinating cross-system programmes of work centred around anti-racism focused quality improvement.

External environment

The MUSIQ-AR domain on external environment focuses on factors outside the organisation(s) where a QI project is being implemented that influence quality improvement, such as policy, regulations, funding, knowledge and community expectations. This considers factors associated with systems working i.e. where more than one organisation seeks to collaborate on a single QI project.

The recommendations that emerged for this domain address evaluation findings in relation to cross-system working, LAN programme expertise and support, peer-peer networking, impact of external events and NHS structure changes.

Cross-system working

Evaluation findings: Cross-system working, which is defined as working across more than one organisation, presented significant challenges for many teams. In several cases, teams reported a lack of formal support or accountability from ICBs and senior leaders. There was limited clarity on who held influence or mandate to align organisations, which hindered efforts to collaborate. Teams also described challenges accessing data across organisations. Where cross-system working was successful, there was early and ongoing senior buy-in, clear governance structures and identified points of contact.

Recommendation: *Strengthen formal accountability, visible leadership engagement and collaborative governance structures to support cross-system working at all stages of QI project delivery. This includes ensuring that system leaders actively participate and help unblock issues that sit at system-level.*

Actions for QI teams

- Ensure formal senior-level commitment exists at the outset of the project (e.g. Chief Nurse, Director of Midwifery, QI lead, data lead, digital lead, PPIE lead).
- Map governance and project management processes early, including meetings, required attendance, reporting forums and communication channels.
- Identify clear points of contact and engagement across partner organisations.
- Consider the full maternity/neonatal care pathway when determining membership of cross-system project teams.

Actions for organisational and system leadership

- Develop mechanisms for ongoing senior engagement in anti-racism focused QI across ICBs, the LMNS and providers to maintain project momentum.

Actions for programme conveners

- Senior national leaders should reinforce expectations for cross-system collaboration in maternity and neonatal services and ensure accountability frameworks support this.
- Engage system leaders in the scoping phase of anti-racism focused QI programmes, ensuring partners are engaged early and consistently.

Programme expertise and support

Evaluation findings: LAN programme expertise strengthened teams' knowledge, skills and motivation to deliver anti-racism focused QI work. However, initial readiness to undertake anti-racism focused QI varied across teams. Some teams reported uncertainty about their starting point, gaps in skills and limited clarity about required pre-work. Teams also identified challenges in aligning work across clinical areas shared by other LAN QI project teams and noted the need for shared pathways or themes to improve synergy and spread learning.

Recommendation: *Programme conveners should help QI teams identify what support and capability building they need and tailor programme support accordingly. Ensure QI project teams feel prepared before project delivery begins and support teams to assess anti-racism QI readiness, for example using MUSIQ-AR. Facilitate alignment of projects and collaborative learning across QI project teams where shared pathways exist, e.g. through change packages that can be adapted to the local context.*

Actions for QI teams

- Conduct QI readiness self-assessments to determine baseline knowledge, capability and starting points (MUSIQ-AR could be used as a tool to facilitate this).
- Where gaps in skills or expertise are identified (e.g. QI, data, anti-racism, involvement of lived experience partners), address these through recruiting additional support or through training. Ensure access to training and development for all team members.

Actions for programme conveners

- Provide clear guidance on pre-work expectations, recommended preparation activities and required resources ahead of programme commencement to ensure teams are prepared.
- Align teams working on similar clinical challenges to develop shared pathway approaches and common tests of change to enhance learning across teams.
- Incentivise cross-system working by developing projects relating to an entire care pathway (rather than a single service, team or intervention), supporting scalability but recognising contextual differences and supporting local adaptation.

Peer-peer networking

Evaluation findings: QI project team peer-peer networking and shared learning opportunities were viewed as highly valuable. Some felt that in-person sessions occurred too infrequently. Online formats did not replicate the engagement levels of in-person sessions, and some clinical areas lacked representation, limiting the breadth of learning. Teams felt that in-person engagement built motivation, energy and focus, and enabled deeper reflection.

Recommendation: *Facilitate opportunities for QI project team peer-peer learning through structured, in-person interactions, while continuing to offer online options for accessibility. Provide funding to mitigate access barriers, e.g. for travel and childcare. Networking should be intentionally designed to bring together teams who do not normally work with each other, creating space for shared learning across different contexts.*

Actions for QI teams

- Encourage team participation in peer-peer learning sessions, rather than a minority of members engaging, to promote shared ownership of QI activities.

Actions for programme conveners

- Provide frequent peer-learning sessions within and across systems, giving adequate notice to support attendance.
- Prioritise in-person networking opportunities where feasible to enhance engagement and collective problem-solving.
- Provide funding to mitigate access barriers, e.g. for travel and childcare.
- Ensure multiple teams conduct project work on the same clinical priority so teams can benefit from comprehensive shared learning.

Impact of high profile influence

Evaluation findings: External events such as senior NHS leadership visits, national attention on ethnic inequalities, or crisis situations, helped projects gain momentum by raising the profile of anti-racism focused QI work. Project affiliation with respected organisations (e.g. RHO, IHI) also encouraged local senior buy-in. Cross-site learning visits were valued for their ability to provide rich, experiential learning.

Recommendation: *Plan high-profile visits and shared learning events to maximise QI project visibility, credibility, and support.*

Actions for QI teams

- Leverage external events (e.g. executive visits, national campaigns) to reinforce the importance of QI projects and promote staff engagement.

Actions for programme conveners

- Facilitate cross-site learning visits between project teams across ICBs or the LMNS to enhance experiential learning and spread of good anti-racism practice.
- Build key external events and national priorities into programme planning from the outset.
- Leverage the national profile of LAN conveners (RHO, IHI) to support local senior engagement and alignment with wider system priorities.

NHS structure changes

Evaluation findings: Frequent changes in NHS structures, such as ICB transitions, created uncertainty around roles, responsibilities and continuity of support. Teams reported that disruption could destabilise QI progress unless strong senior leadership maintained alignment. Where QI work remained on track, leaders played a crucial role in providing consistency and navigating structural changes.

Recommendation: *Embed senior cross-system support to ensure continuity and resilience during periods of organisational change. Clear oversight will help maintain stability, provide a consistent point of escalation and ensure projects remain on track even when structures or responsibilities shift.*

Actions for organisational leadership and system leadership

- Develop mechanisms for ongoing senior engagement across ICBs, providers and LMNS to maintain project momentum.
- Ensure senior leaders across ICBs and LMNS provide consistent support and clear communication during organisational transitions.
- Re-affirm commitments to anti-racism focused QI projects when structural changes occur to maintain stability and momentum.
- Align priorities and resources across organisations to mitigate disruption.
- Consider commissioning community organisations to deliver resilience training for QI project teams.

Actions for programme conveners

- Provide guidance on maintaining anti-racism QI continuity during organisational reforms, including clarity on responsibilities, escalation routes and expectations for cross-system collaboration.

Organisation

The MUSIQ-AR domain on organisation focuses on the overall structure, culture, leadership, and resources of the healthcare organisation that supports or hinders anti-racism focused quality improvement.

The recommendations that emerged for this domain address evaluation findings in relation to anti-racism culture, politics and initiatives.

Anti-racism culture and initiatives

Evaluation findings: Projects moved forward more easily in organisations where it was already normal practice to openly talk about racism and actively work to oppose it. This included having anti-racism policies, programmes and practices already in place.

Recommendation: *Organisations should conduct a structured assessment of their current anti-racism maturity, identify gaps, and develop a clear, time-bound action plan to embed anti-racist principles across policies, practices, and culture. This commitment should be visible, measurable, and supported by leadership accountability. Organisations may find the Race Equity Maturity Index, developed by the London Anti-Racism Collaboration for Health, helpful. Engage in cross-organisation sharing/learning.*

Actions for organisational and system leadership

- Senior leaders (irrespective of their ethnicity) should reflect at both personal and organisational levels about anti-racism.
- Senior leaders should be encouraged to utilise tools, e.g. the [Race Equity Maturity Index](#), and engage in activities to reflect on anti-racism.
- Actively share anti-racism work with and learn from other organisations.

Organisational support for QI projects

Evaluation findings: Some project teams were within organisations that support QI projects by providing technical expertise and/or financial resources. For example, this included support from data specialists, patient and public involvement and engagement (PPIE) specialists, research teams, programme management, and anti-racism and trauma-informed expertise. Whilst some teams were within organisations that could offer this type of support, others were not, and the picture was varied across project sites.

Recommendation: *Organisational-level support for anti-racism focused QI projects should include dedicated technical expertise (e.g., data analysis, programme management, anti-racism and trauma-informed practice), financial resources, and access to specialist teams such as patient and public involvement (PPIE) and research.*

Organisations should embed these capabilities as core infrastructure for QI, ensuring equity of access across all sites and reducing variability in support. Consistent access to necessary resources may be secured by mobilising support from stakeholders across the system.

Actions for organisational and system leadership

- Anti-racism focused QI should be part of management and leadership training, including for clinical leaders, within NHS Trusts.
- Provide dedicated technical expertise (e.g., data analysis, programme management, anti-racism and trauma-informed practice), financial resources, and access to specialist teams such as PPIE and research, and embed these capabilities as core QI infrastructure.
- To support local level actions, the NHS IMPACT (Improving Patient Care Together) recommendations should be leveraged.
- Develop ICB or Trust objectives that require greater collaboration with the Local Maternity and Neonatal System.

QI Project Team

The MUSIQ-AR domain on QI project team focuses on the group responsible for planning and implementing ant-racism focused quality improvement, including their skills and collaboration.

The recommendations that emerged for this domain address evaluation findings in relation to team composition, ethnic diversity within teams, lived experience partner involvement, and project team capacity.

Team capability

Evaluation findings: QI teams that include people from different professional backgrounds (a multi-disciplinary team) and have members dedicated to the project are better able to handle challenges and have the necessary skills to successfully carry out QI projects. Teams best suited for running QI projects included people with expertise in: QI methods, project management, data analysis, relevant clinical experience, anti-racism, working with lived experience partners and senior leadership representation.

Recommendation: *Strengthen capability within project teams, including around QI; data management, capture and infrastructure; and anti-racism, equity, diversity and inclusion. Make engaging, interactive training available on an ongoing basis. Provide debriefing and emotional support for project team members.*

Actions for QI teams

- Set up a multi-disciplinary QI project team, incorporating expertise in: QI; data infrastructure and management; anti-racism, equity, diversity and inclusion; clinical expertise and project management (see also sections below on *ethnic diversity* and *lived experience partners* when assembling project teams).

Actions for organisational and system leadership

- Key staff in participating organisations, including the nominated QI Lead and senior leadership team, should be responsible and accountable for QI team composition.

Actions for programme conveners

- Develop a comprehensive support offer, such as the offer delivered via the LAN, to ensure QI team members have the required expertise or are upskilled in QI.
- Ensure there are appropriate mechanisms for debriefing and emotional support for QI team members.
- Learnings from the LAN should be disseminated among wider system stakeholders, including within other RHO programmes.
- Stakeholders recognise the value of the maternal and neonatal LAN becoming business as usual and suggest the RHO should roll it out nationally. This rollout should be accompanied by training in anti-racism, unconscious bias, equity, diversity and inclusion.
- External bodies (for example the Health Innovation Networks and Academic Health Science Centres) could be well placed to strategically support programmatic implementation and evaluation.
- Engage regulators for midwifery and maternity services to enhance the success of QI projects.

Ethnic diversity within teams

Evaluation findings: It works best for QI project teams to include members from different ethnic backgrounds. This ensures that relevant experiences and viewpoints are part of all project activities. Having an ethnically diverse team also makes it easier to connect with patients and staff from the Global South. Not all core teams had ethnic diversity. In these cases, additional support from global majority colleagues or lived experience experts was needed to make project work culturally aware and appropriately delivered.

Recommendation: *Ensure project teams are intentionally diverse in ethnicity and lived experience. Establish clear criteria and transparent processes for team formation, including how and when members are selected.*

Provide structured support for all team members, recognising that individuals will be at different stages in their learning journey, and embed opportunities for reflection and development throughout the project lifecycle and beyond.

Actions for QI teams

- Ensure QI project teams are ethnically diverse.
- Contributions from all project team members should be appropriately recognised, such as QI experts, midwives, and lived experience partners.

Actions for organisational and system leadership

- Ensure QI project teams are ethnically diverse.
- Recognise the diverse backgrounds of QI team members and the respective journeys they are on.

Actions for programme conveners

- Support individuals to learn and self-reflect by embedding a culture of continuous learning, including providing protected time for reflection.

Lived experience partner involvement

Evaluation finding: For some projects, involvement of lived experience partners was limited to the three-part data review. Other teams made a strong effort to involve lived experience partners more continuously and had them work together on different parts of the project's plan and delivery. In some organisations, involving partners with lived experience was already a standard way of working, which made it much easier for those projects. One obstacle preventing more effective involvement of these partners was a lack of funding to reimburse people for their expertise and time.

Recommendation: *Expand and embed the role of lived experience partners. Their involvement should go beyond consultation to active participation in shaping priorities, co-designing change ideas, and contributing to decision-making throughout the entire QI lifecycle. This includes ensuring lived experience partners have the resources, training, and support needed to influence project planning and delivery meaningfully, and that they are offered appropriate incentives for their time and expertise.*

Actions for QI teams

- Embed lived experience partners within anti-racism focused QI.
- Lived experience partners should have a key role in defining the focus of the QI project.
- Identify additional areas of the QI project lifecycle where lived experience experts will be involved.

Actions for organisational and system leadership

- Allocate sufficient and ring-fenced funding to ensure lived experience partners can participate fully and equitably. This should cover fair remuneration, travel and childcare costs, accessibility needs, and training or capacity-building opportunities. Budgeting should reflect the value of their expertise and enable sustained engagement throughout all phases of the project.

Actions for programme conveners

- Support organisations and QI teams to understand the value and role of lived experience partners in anti-racism focused QI.

Project team capacity

Evaluation findings: Implementing anti-racism-focused QI projects was challenging due to limited team capacity and difficulties engaging frontline staff. Clinicians faced significant time and resource constraints, often working beyond their core roles. Workforce pressures, staff turnover, and clinical rotations compounded these challenges, making sustained engagement difficult. Teams with dedicated project management or access to QI expertise were better able to maintain momentum. Additionally, variable cultural competence and systemic racism further hindered frontline participation.

Recommendation: *Provide dedicated project management and clinical staff resourcing for anti-racism focused QI projects to ensure delivery is sustainable and impactful. This should include allocating protected time for clinicians, embedding skilled project managers within teams, and providing access to specialist expertise (e.g., data analysis, equity and anti-racism).*

Adequate resourcing is critical to maintain momentum, reduce reliance on staff working beyond their core roles, and enable consistent progress

across all phases of the QI lifecycle.

Actions for organisational and system leadership

- Allocate dedicated time for participation in QI projects. Commissioning should support teams to backfill time to engage in anti-racism focused QI activities.
- Review and adapt staffing models (e.g., Birthrate Plus) to reduce burnout and enable QI engagement.
- Embed skilled project managers within each QI team and provide access to specialist expertise.
- Establish communities of practice and leverage Professional Midwifery Advocates to build improvement capacity and provide restorative clinical support.
- Deliver structured training and provide reflective learning opportunities to enhance cultural humility and anti-racism practice.

Infrastructure

The MUSIQ-AR domain on infrastructure focuses on the system, tools and support mechanisms (e.g. data systems, training and improvement frameworks) that enable anti-racism focused QI activities.

The recommendations that emerged for this domain address evaluation findings in relation to local data access, organisational level support for QI projects and frontline staff engagement. This section focuses on data access, as recommendations for the latter have been covered in previous sections.

Local data access

Evaluation findings: Teams with access to good quality, ethnicity disaggregated service and clinical outcome data were well prepared to design and monitor projects that targeted ethnic inequalities. Access to this data varied across projects, dependent on the quality and completeness of organisational level data. Those working at a system level or across Trusts found accessing organisation level data challenging. Teams with existing Health Inequality Dashboards benefitted significantly.

Recommendation: *Strengthen efforts to ensure robust and equitable access to high-quality, ethnicity-disaggregated data at both QI project and national levels. Baseline data collection should be prioritised and used to inform QI team selection, project design, and training.*

Comprehensive capacity building on data access and utilisation must be provided to all QI teams. At the national level, urgent action is needed to address systemic challenges such as lack of data standardisation, variations in data maturity, and interoperability issues.

These improvements should be supported by clear governance, accountability frameworks, and sustained funding to guarantee consistency, comparability, and reliability across all anti-racism focused QI initiatives. The NHS England Ethnicity Recording Improvement Plan may support organisations.

Actions for organisational and system leadership

- The LMNS and Trust Boards need to strategically drive improvements in local data access and quality. Key actions can be delegated to operational teams. There should be joint working with CQC and safeguarding organisations to improve local data access, given their focus on addressing health inequalities.
- Improvements in local data access and quality should be tied to national-level legislation and the Trust Board's responsibility for delivering safe care. Key legislation, strategies and frameworks to leverage include: equity, diversity and inclusion legislation, such as the Equality Act 2010; the Health and Care Act 2022; NHS Patient Safety Strategy, which is due to be refreshed; NHS England Patient Safety Healthcare Inequalities Framework, which includes the principle of utilisation of data for improvement; Maternity Incentives Scheme, which is updated on a yearly basis.
- Use the NHS England [Ethnicity Recording Improvement Plan](#) (published October 2025) to identify and act on issues that affect ability to record and analyse ethnic health inequalities data.
- Trusts could make it mandatory to ask about ethnicity in patient safety incident reporting systems.
- These actions ought to be incorporated into local planning guidance so governance structures can promote accountability.

Actions for programme conveners

- Provide training and support on ethnicity disaggregated data access and utilisation for QI project teams.
- Champion the urgent need to improve ethnicity disaggregated data, influencing interest holders at national level.