Health Innovation West of England

Findings from the evaluation of the Black Maternity Matters Programme (Cohort 2 – full report)

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Assurance rating

*This report can be used for context and background information	
**This report can help inform decision making, when considered with other information	✓
***This report is the best available evidence to date	

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Full report

A copy of the full report can be found on the Heath Innovation West of England website here: www.healthinnowest.net/blackmaternitymatters/.

Contents

Where has the Black Maternity Matters collaborative come from? ... 5
Language in this report ... 5
The national and policy context ... 5
Why focus on anti-racism now? ... 7
Understanding anti-racist cultural competence ... 7
The challenge of defining cultural competency ... 7
Cultural competence as a way to address poor outcomes and health inequalities ... 8
How does poor culturally competent practice show up health services? ... 8
Theory of change ... 9
The Black Maternity Matters cohort 2 intervention ... 10
Evaluation methods ... 11
Aims and objectives ... 11
Theoretical framework ... 12
Study design, setting, sampling and recruitment ... 12
Data collection, management and analysis ... 13
Quantitative data: ... 14
Evaluation governance ... 15
Findings ... 15
Qualitative data ... 21
Course attendance ... 21
Motivation to join ... 21
Information planning and staff inclusion ... 22
Course design and length ... 25
Transfer of knowledge and creation of skills ... 26
Discomfort during learning ... 28
Book clubs ... 32
Quality improvement data ... 34
Quality improvement training – mechanism for addressing change ... 37
The practicalities of fitting in the sessions ... 39
From theory to practice: creating action ... 42
Evaluation strengths and limitations ... 45
Discussion ... 46
Conclusion ... 50
References ... 51
Appendices ... 56
A1: Timeline of the programme components for cohort 2 (2023/24) ... 56
A2: The refined Theoretical Domains Framework ... 57

A3: Cohort 2 demographic data (n=25) 58
A4: Use of language in this report 59

Where has the Black Maternity Matters Collaborative come from?

In 2022 the Black Maternity Matters initiative was co-designed with Black Mothers Matter, Representation Matters, BCohCo and Health Innovation West of England and implemented using improvement methodology, alongside the delivery of anti-racist training. The pilot was designed to deliver meaningful, actionable improvements to reduce inequity of outcomes for Black women within maternity systems through a collaborative quality improvement (QI) approach. Improvement methodology is a popular approach to conducting tests of change to support quality improvement in healthcare[1]. Using PDSA cycles in this way can help deliver improvements in patient care through a structured experimental approach to learning and tests of change.

Pilot programme components included a QI collaborative of midwives and maternity support workers (MSWs) to support psychological safety, peer support and QI coaching. A core component of the pilot was the delivery of an anti-racist training programme for midwives and MSWs. The training education aimed to examine unconscious biases and the role of the individual in perpetuating unsafe systems of care for Black women. Following this, the pilot aimed for midwives and MSWs to co-produce and implement small tests of change aimed at optimising outcomes for Black women within maternity systems. The pilot programme was evaluated and learning from the evaluation was used to make refinements to delivery and pave the way for further programme developments[2].

At the start of the Black Maternity Matters pilot the West of England had not yet developed a targeted, unified strategy to optimising outcomes for Black pregnant women, birthers and their babies. Where training and education has been offered, maternity system staff have often been left with no clear steps to test actionable and meaningful change within a supportive QI collaborative, offering coaching and peer support.

The subsequent Black Maternity Matters collaborative has continued to develop programme components aiming to address these gaps, which all seek to address the impacts of racism on women and birthers. This evaluation reports on one of these work packages delivering specific training and education for cohort 2 which ran during 2023.

Language in this report

A growing number of transgender and non-binary people are becoming gestational parents. To reflect that this report is inclusive of all gender identities, we have used the language of women and birthers to describe gestational parents.

Guidance on writing about ethnicity was taken from the Government website[a]. In line with the guidance, we do not use the terms BAME (Black, Asian and minority ethnic) and BME (Black and minority ethnic). Throughout this document we have used the term "racially minoritised" when talking about people who are not racialised on sight as White British. This is to ensure the distinction between ethnicity and race, and to recognise that whilst race is a social construct, the way that people are racialised by others causes individuals and groups to be treated differently and to experience a range of inequalities and poor outcomes as a result. More information on the difference between race and ethnicity can be found in Appendix A4.

The national and policy context

Analysis of maternal deaths, stillbirths and neonatal deaths undertaken by 'Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries'[3] across the UK showed

[a] https://www.ethnicity-facts-figures.service.gov.uk/style-guide/writing-about-ethnicity/

that poor outcomes are higher for mothers, birthers and babies from Black and Asian ethnic groups. This is particularly evidenced for those born in Asia or Africa, and for women living in the most deprived areas of the country.

The MBRRACE-UK report[3] highlighted that Black women are four times more likely to die during pregnancy or in the postnatal period than White women, and for Asian women, twice as likely to die. Stillbirth rates of Black and Black British babies are over twice those for White babies[4]. In addition, it is accepted that there are inevitable 'near misses', experiences of poor care and psychological impact that have not yet been a focus of research, further adding to the burden of trauma carried by Black women.

The reasons for the disparity in health outcomes for some women and birthers during pregnancy are described as a "constellation of biases"[3]; argued as systemic biases which prevent women and birthers with complex or multiple problems receiving the care they need ante and postnatally. Specifically for Black and Asian women unconscious bias, stereotyping and lack of diversity competency all have the potential to result in health services that disadvantage those from racially minoritised backgrounds[5].

Denial of the impacts of racism contrast directly with increasing data from a healthcare perspective where there are clear and persistent health inequalities across the UK in both length of life and in length of healthy life, for both men and women[6]. Accounts of inequalities in perinatal outcomes, access and experiences are widely acknowledged in the literature[1]. As noted in the national context, whilst pregnancy in the UK remains safe, it is by no means equal[7]. The MBRRACE-UK report highlights differences in maternity outcomes for women and their babies from different ethnic groups and those who live in more deprived areas. Alongside other recent national data, it evidences the uncomfortable truth that there remains a nearly four-fold difference in maternal mortality rates amongst women racialised as Black and an almost two-fold difference amongst women racialised as Asian, when compared to White women[3].

A Maternity Transformation Programme was launched by NHS England following the Better Births report[8]. The policy plans for transformation have re-ignited the focus within integrated care systems (ICSs) about what is needed to improve equity of perinatal outcomes[9]. As a development in England this has led to the creation of Local Maternity and Neonatal Systems (LMNSs), bringing providers and commissioners together to achieve the vision set out in Better Births. Despite clear policy direction, healthcare systems (and its actors) are left grappling with what the concept of institutional racism means for them professionally and personally, while struggling to identify the solution to a problem they often don't fully understand[10]. In accepting that racism constitutes a barrier towards achieving equitable healthcare, the racial attitudes or beliefs of healthcare staff demonstrate a range of negative stereotypes regarding racialised minoritised users of healthcare, who may be viewed as difficult[11,12].

The barrier to equitable healthcare arising from racism, has led to the identification of cultural-specific support and cultural competency training for healthcare professionals as an area of interest in addressing the healthcare inequalities that some women face in maternity systems[13,14]. Research has revealed midwives view communication as a key component of cultural competence, whilst not necessarily understanding the concept "cultural competence" itself[10]. In other research, whilst midwives benefited from this kind of training, many were unaware of the factors influencing the care of women and babies from Black, Asian and racially minoritised families. This highlights a need for more specific understanding of the disconnect between staff awareness of implicit racial bias and how it impacts these women when giving birth[15]. Increasingly, questions are being asked which specifically seek to

understand the role of professionals in addressing the existing structural inequities, and how this may best be achieved.

Why focus on anti-racism now?

The murder of George Floyd in 2020 in the USA acted as a catalyst for a series of global events that uniquely cast a spotlight on the impacts of racism on societies around the world. Social and political movements, such as Black Lives Matter, grew to become the biggest in recent history, leading to anti-racist demonstrations, the removal of statues and renaming of buildings and streets that were associated with slavery and enduring racist symbolism. With its origins in the USA, Black Lives Matter was intended as an 'umbrella statement' that was broad enough to draw attention to multiple policy areas in society and challenge social and political norms across the criminal justice system, education and healthcare[16]. It has now become a global movement which seeks to highlight racism, discrimination and racial inequality by Black people, and to promote anti-racism.

The high-profile nature of the attention on this topic has sparked an exploration of how institutions in the United Kingdom (UK) respond to racism, and the resistance faced by many in seeking to dismantle racial capitalism[b] and patriarchy. This renewed focus has opened up discussion on the role of White privilege[c] in healthcare and institutional racism, often to be met by resistance and denial of the problem, as actors within these systems struggle to recognise the scale of the problem facing racially minoritised groups in the UK[17].

Understanding anti-racist cultural competence

The challenge of defining cultural competency

While midwives might benefit from anti-racist training, many remain unaware of the factors influencing the care of women and babies from Black, Asian and racially minoritised families, highlighting a need for more specific understanding of the disconnect between staff awareness of implicit racial bias and how this impacts those giving birth[15]. Increasingly questions are being asked that specifically seek to understand the role of professionals in addressing the existing structural inequities, and how this may best be achieved.

Culturally competent care, and latterly anti-racist practice have been identified as both a legal and a moral requirement for health and social care professionals[18,19,20]. It can be difficult to find an accepted definition. One widely used description defines it as a set of congruent behaviours, attitudes, policies, and structures that come together in a system among professions, which enables professionals to work effectively in cross cultural situations[21,22]. The behaviours, attitudes and policies that underpin cultural competence are intended to be adopted and practiced at both individual and organisation levels, where the individual is capable of practicing effectively in contexts of cultural difference. An individual who is culturally competent should value diversity, self-assess cultural competence and be aware of (and manage) the dynamics of difference[23].

At an organisational level, services should demonstrate cultural knowledge and adapt their services to fit the diversity of those they seek to serve[12,23,24]. Some research tends to examine cultural variations as disparities in health understanding across or within different population groups, particularly when working with indigenous people, their understandings and how this might vary from White-centric driven approaches to health (often described as

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[b] **Racial capitalism** is a concept reframing the history of capitalism as grounded in the extraction of social and economic value from people of marginalized racial identities, typically from Black people. Source: https://en.wikipedia.org/wiki/Racial_capitalism

[c] **White privilege**, is the societal privilege that benefits white people over non-white people in some societies, particularly if they are otherwise under the same social, political, or economic circumstances. Sources: https://en.wikipedia.org/wiki/White_privilege

‘mainstream’ perceptions of healthcare)[24, 25,26]. Other research tends to focus on communication challenges and how this affects clinical interactions between the health professional and patient[27]. Whilst there is strong evidence that cultural competence should work, there is often no information that helps to determine what combination of cultural competence methods work, when and how to apply them appropriately, or perhaps most importantly how to quantify culturally competent performance in health systems at all levels[28]. Health systems often have very little evidence about which techniques are effective and when and how to implement them properly[29].

Cultural competence as a way to address poor outcomes and health inequalities

Cultural competence education for health professionals has emerged as a strategy in high-income English-speaking countries, particularly in response to evidence of health disparities, structural inequalities and poorer quality healthcare and outcomes in racially minoritised groups[24]. In moving cultural competency forward, evidence appears to suggest that professionals struggle with their progress on this topic. For example, most are unable to even confirm that their clinical practice is anti-racist and culturally competent[24]. Some current methods to build cultural competence have been chastised for commodifying and appropriating culture, which has resulted in stereotyping and additional disempowerment of patients. This highlights the complexity of adopting culturally competent models which are tailored to communities and cultures[28].

A systematic review[24] to assess cultural competence education interventions for health professionals found a paucity of evidence to link cultural competence with patient, professional and organisational outcomes, which would appear to still be relevant 10 years on. Findings either showed support for educational interventions or no evidence of effect. The heterogeneity of the interventions (content, scope, design, duration, implementation, and outcomes selected) made it hard to draw generalisable conclusions. There is a need to establish uniformity on core components of education interventions, including how they are described and evaluated. Measuring the impact of cultural competency educational interventions on healthcare organisations is important, as these are likely to affect uptake and sustainability.

We would argue simplistic understanding of racial identity and the importance of personal culture underpins much of the evidence. This over-simplification of culture needs can lead to racially minoritised groups being represented as homogenous, where the role of racism is often ignored. Limited understanding of race and culture by health practitioners can lead to stereotyping and mislabelling of healthcare users as high risk even in the absence of risk factors[25].

How does poor culturally competent practice show up in health services?

A country’s maternity care is largely based on the needs of the women from the ethnic majority and often lacks the flexibility to meet the needs of racially minoritised or immigrant women and birthers[13]. This in turn can create challenges for those accessing maternity care. Barriers such as language and culture, along with social isolation and separation, low income, poor housing and work schedule all contribute to poor maternity healthcare access with deleterious effects.

Women from lower socioeconomic groups have been refused pain relief during their labour, and pain relief provision was dependent on the skills and knowledge of the attending midwives[30]. Refusal to provide pain relief appears to be one example to highlight culturally incompetent care as part of the clinical processes but in other evidence it is misconceptions with specific racial stereotyping that can lead to the poor experiences of some women and

birthers. Healthcare professionals' beliefs about pain are often inaccurate, where general cultural beliefs about labour pain are associated with racial biases, and explicit beliefs that racially minoritised women experience less labour pain than White women[31]. During midwife-woman relationships with migrant Pakistani women in South Wales, midwife perceptions of mother-in-laws were reported as 'dominating' antenatal clinics, preventing them from getting to know women[11]. Similarly, the male partners' propensity to speak on behalf of Pakistani women, even when they appeared to have sufficient language skills, was perceived negatively by midwives who stereotyped it as an act of male dominance and control. Some of this prejudice was more explicit when midwives had not yet established a positive relationship with a mother, which then led them to judge more harshly some of the women's decision-making[11].

Women and birthers take their own cultural views on care with them when they are in hospital settings; once in hospital settings they go on to be met with the values and beliefs of their caregivers[27], and here we begin to see intercultural care encounters that can lead to misunderstandings between those receiving and providing care in healthcare settings. Women and birther's cultural context cannot be seen as a static set of values, preferences or traditions, but should be better understood as a dynamic process where a symbolic, emotional or moral meaning is brought to their experience of giving birth[27].

Evidence suggests focusing solely on a woman or birther's cultural context when addressing issues may lead to an overemphasis on finding practical solutions to cultural practices. However, practical solutions to visible religious and cultural tensions are insufficient on their own to provide appropriate intercultural care. The concern is that such an approach could reduce care to a technical task, overlooking its deeper moral and ethical dimensions.[11]. This suggests a need to shift away from an individualised idea of culture in healthcare, where the culture of racially minoritised women can be interpreted as individual deficit that needs to be taken care of by caregivers.

Denial of the impacts of racism, racial bias and stereotyping[17,32] contrast directly with increasing data that spotlights the persistent health inequalities across the UK for racially minoritised women[3]. The work of the Black Maternity Matters collaborative provides an opportunity to understand the role of healthcare professionals in addressing the institutional and structural inequities of racism.

Theory of change

The programme team have developed a theory of change for the Black Maternity Matters programme work to help inform development of their activities. The programme aims for individual targeted anti-racism training (through an anti-Blackness lens[d]) for the perinatal care workforce, delivered system-wide in the West of England. This work will result in:

1. Individual and system level transformation, reduction in unconscious and conscious expression of racism in perinatal care.
2. Reduction of unconscious and conscious incidences of racism and a reduction in harm to Black women, birthers and babies within perinatal systems.
3. Reduction in expression of unconscious and conscious incidences of racism between team members.

[d]**Anti-Black sentiment**, also called **anti-Black racism**, **anti-Blackness** or **Negrophobia**, is characterised by prejudice, collective hatred, and discrimination or extreme aversion towards people who are considered Black people, such as sub-Saharan Africans, as well as a loathing of Black culture worldwide. Source: https://en.wikipedia.org/wiki/Anti-Black_sentiment

4. Improved team dynamic and psychological safety in perinatal teams because of the transformation to anti-racist organisations.

The Black Maternity Matters cohort 2 intervention

Our initial pilot for Black Maternity Matters was hosted in one Integrated Care Board (ICB) locality in Bristol, recruiting midwives and maternity support workers from two NHS trusts to attend the training. Implementation of the second cohort reflected the learning recommendations that had been identified throughout the pilot, and from the initial evaluation.

The anti-racist training programme in cohort 2 was delivered in the same format as the pilot over a six-month period. It comprised of three full-day in-person sessions with two trainers (m1, m3, m5) and online book club sessions (half-day) with two trainers (m2, m4, m6). As part of enrolment to the programme, respondents were only offered a place on the course if they could commit to attending all of the face to face and book club sessions.

In comparison to the pilot, where QI training was delivered at the end of the programme, cohort 2 offered flexible QI training online throughout the six-month period of training (n=3). The QI sessions were delivered online using MS Teams and Miro Board. Each session was delivered three times followed by a drop-in clinic sessions for Q&A and were delivered across the cohorts (mixing respondents). See Appendix A1 for a programme timeline. Table 1 sets out intervention components.

Another key change to the programme delivery was the extended inclusion criteria for who could attend the course. Participation was extended to include a range of staff from across the perinatal system (including neonatology and obstetrics) and was therefore open to midwives, maternity support workers, staff in leadership roles, health visitors, junior doctors and those in community nursing roles (such as family nurses).

Cohort 2 was delivered across three (integrated care system) ICS regions in the West of England, which incorporated five acute NHS trusts, three ICBs and staff from community NHS trusts. To allow greater flexibility for attendance across the cohort, respondents were able to attend training sessions from outside of their area and join another group if they were unable to attend all sessions in their locality.

The initial pilot programme recruited two midwife champions who acted as peer support and change agents between the training group and their employing organisations. In comparison in cohort 2, the role was expanded to become a maternity champion (thus not restricting the role to midwives).

Each training cohort had their own WhatsApp group chat (or equivalent), which enabled communication and peer support between the training sessions and encouraged group collaboration.

Table 1: *Intervention components*

Session	Training Content	Length
F2F S1	**Who Am I** – An exploration of individual values and beliefs **The Business Case for Anti-Racism** – A deep dive into why we need to build Anti-Racist organisations **Rooting it in the real** – A quantitative and qualitative overview of living whilst Black and Brown in 2023 **The Equalities Act 2010** – Examine how Race is protected by British law **Bias** – An overview of Bias in all its complexity **Understanding Whiteness –** A historical exploration **The Dimensions of Racism –** Assess how Racism is embedded	1 day

Session	Training Content	Length
BC1	Online session book club	½ day
F2F S2	**The political landscape –** Consider how reports have influenced this work and central governments current position **Privilege distress** – How privilege distress manifests and how to manage it **The impact of Racism** – An exploration of how racial trauma influences interpersonal interaction **Colorism –** The Race spectrum and how this impacts individuals at different positions on the scale **Hairism –** Different hair textures and Eurocentric ideas of beauty **Anti-Blackness –** An exploration of Anti-Blackness and how it differs from Racism	1 day
BC1	Online session book club	½ day
F2F S3	**The Power of Language –** Defining terms when describing identity **Understanding who we're dealing with –** Consider the different types of opposition that present when tackling Racism **Four Dimensions of Combating Racism –** Understand the different context in which we need to use Anti-Racist practice **Building the Tools –** Assessing the various methods available to challenge Racism **Effective Communication in Challenging Racism –** Explore different approaches to challenging interpersonal Racism	1 day
BC3	Online session book club	½ day
QI S1 (online)	**Generating Ideas for Change** Respondents will be introduced to the steps in the IHI Model for Improvement Respondents will be able to use and apply the following tools from the Creative Problem Solving Toolkit to generate ideas: Lotus Blossom, Pictures as Prompts How would… do it? TRIZ Respondents will understand how to make decisions to select ideas to take forward as tests of change	90 mins
QI S2 (online)	**Overcoming Obstacles for Change** Respondents will be introduced to the human dimensions of change through two models: Rogers Diffusion of Innovation curve The Change Curve model (adapted from Elisabeth Kubler-Ross) Respondents will be able to use and apply galaxy mapping as a tool to understand stakeholders. Respondents will be introduced to key concepts in behavioural science including: How to define a target behaviour How to use the EAST framework to select behavioural change interventions to overcome barriers to change.	90 mins
QI S3 (online)	**Strategies for Getting the Word Out** Respondents will be able to construct and apply a communication plan for their project exploring the rationale, stakeholders, key messages, communications channels, timetable, and measurement of success. Respondents will explore ways to share their learning and outcomes. Respondents will participate in a peer-to-peer coaching session to consolidate their learning from the course.	90 mins

Evaluation methods

Aims and objectives

An independent mixed-methods evaluation was undertaken to understand the impact of the programme components to deliver improvement in the outcomes for Black mothers in maternity systems. The primary evaluation aim was to understand the impact of the anti-racist and QI training for perinatal staff from across three ICB regions. The overarching aims of the programme were:

a) To influence health disparities associated perinatal outcomes for Black mothers and birthers at individual and systems level, creating change in local settings.
b) To engage with local partners from across the maternity and neonatal system to leverage the system drivers to create change for those who are racially minoritised.

From the overarching programme aims, specific evaluation questions were designed to better understand the programme impact:

i) Does the model for multi-disciplinary perinatal team training improve anti-racist competency (knowledge and skills) and practice (improvement in clinical settings)?
ii) Has the QI training improved the knowledge, skills, confidence and capability levels in staff of improvement methodology approaches to address health disparities?
iii) What is the impact of the programme on staff perceptions of psychological safety to practice and implement anti-racism in their place of work?
iv) Does a multi-disciplinary perinatal team (a mix of operational and managerial staff) training approach better facilitate anti-racist competency and quality improvement practice?
v) What evidence is there of increased knowledge, skills and competencies translating into anti-racism action within NHS trust and community settings?

Theoretical Framework

Implementing innovations or interventions often requires changes in the behaviours of healthcare professionals, and this is helped by understanding what determines current or desired behaviours. The Theoretical Domains Framework (TDF) was first developed in 2005 (revised 2012)[33] and aimed to provide a comprehensive, theory-informed approach to identify determinants of behaviour. It is one of the most commonly used frameworks in implementation science. It was chosen to improve our insights on the design and implementation of the anti-racist intervention by systematically addressing the psychological, social, and environmental factors involved in healthcare professionals' behaviours. For example, how knowledge, attitudes, and beliefs about race influence healthcare professionals’ actions or pinpointing specific barriers (like lack of training or biases) and facilitators (such as supportive policies) that affect the success of anti-racist interventions.

Using a conceptual framework with a behavioural change focus offers insight into how healthcare providers can shift their practices toward more equitable care. Determining the factors that influence a given behaviour is essential for any successful intervention that aims to change existing behaviour. Evidence demonstrates that behaviour change interventions based on theory are more effective than those without a theoretical base. And the effectiveness of a theory-based intervention may also increase with the number of theories incorporated. The TDF now consists of eight constructs (component parts of theories), which are sorted into 14 domains. Appendix A2 shows a table of the different domains and those identified for use in the analysis of data for this evaluation.

It is worth noting that the TDF framework helps to identify and describe the factors that influence a behaviour, rather than explain it or offer causality about determinants in any given context. In this sense it offers a theoretical lens through which to view cognitive, affective, social and environmental influences on behaviour. Rather than providing an explanation of change, it offers a list of factors that could potentially influence behaviour. We have used the domains to frame the thematic analysis of the data and draw insight into the discussion section of this report to help answer the evaluation questions.

Study design, setting, sampling and recruitment

A series of quantitative and qualitative data collection approaches were designed and data collected encompassed nine of the 12 TDF domains to improve the validity and reliability of the findings[34]. Qualitative data was collected to provide insights into underlying complex social processes.[35] Quantitative data was collected to enable the identification of patterns of similarities and differences. Data was collected at baseline and again at the end of the

programme (Table 2). The multiple data sources and time points enabled cross-referencing to further enhance the robustness, reliability and validity of the evaluation[34].

Quantitative data collection

A measure of cultural competency[e] was used pre and post-training (at baseline and six months) to evidence the knowledge and insight generated by completing the holistic training package. This was to support the primary aim of understanding the impact of the anti-racist training. At the end of the training programme (six months), the measure was repeated by the training respondents (achieving paired data sets n=27). Using paired data sets in this way allows for direct comparison, reducing variability due to individual differences, leading to more precise estimates of the training effect.

In addition to this, two validated measures for behaviour change[39] and psychological safety were completed at baseline and at six months. A non-validated measure of QI experience was also completed.

Qualitative data collection

After the last face to face training session in month six, we conducted a focus group with each site cohort. The focus groups lasted approximately 60 minutes each and respondents self-selected to attend. Each group was audio recorded and transcribed for analysis, with respondents anonymised, and any identifying information removed.

In addition to the focus groups, all those in maternity champions roles (n=6) were invited to attend an in-depth interview to share their views on their experiences of this additional role and its impact on their local training cohort. Five interviews were conducted using video conferencing software by the same evaluator (MS Teams).

Data collection, management and analysis

Qualitative data analysis

All interviews and focus group data were collected between October and December 2023. Each were transcribed and checked for accuracy. Interviews lasted between 45 to 75 minutes. Audio recordings and transcripts were stored on secure networked drives by Health Innovation West of England. Interview guides were developed by the Evaluation & Insight team according to the evaluation aims and objectives and drew on the pilot evaluation insight.

Data were analysed inductively by the main evaluator and for quality assurance purposes early insights were shared with the programme team[36,37,38]. A thematic structure to summarise and classify data was created using a coding framework linked to TDF[33]. Text was coded to represent themes and help facilitate exploration of the data from a range of respondents. During analysis, evaluators met to discuss the coding framework at different steps of the analysis to form a range of final themes and ensure rigour to the process. This was shared with the programme steering group for additional sense checking and feedback. Quantitative and qualitative data are used to triangulate emerging themes within the TDF, which are presented in the findings section of this report. Using triangulation in this way increases the credibility and validity of findings by confirming results through multiple data sources or methods, allowing for cross-verification. This reduces the risk of drawing incomplete or biased conclusions. Triangulating data helps capture complexities by combining measurable outcomes with personal perspectives or narratives, leading to more actionable and informed recommendations.

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[e] https://www.cvims.org/resources/cultural-competency/

Quantitative data:

Collection

Survey data was collected using Zoho Survey™ and distributed to all training respondents by email ahead of their first training session, and again at the end of their final training session. Respondents were encouraged to complete their questionnaires as close to their final attendance as possible, and data collection period was extended for the final group to optimise the numbers completed. Questionnaires closed on 20 December 2023 to allow for analysis. Email reminders were sent to respondents to encourage completion.

Data cleaning

After the survey was closed on Zoho Survey, the respondent data was downloaded as an Excel file. The data was cleaned to ensure quality and accuracy. This cleaning process involved removing duplicates as there were multiple entries from the same respondent and the format was standardised to ensure easier analysis.

Data analysis

Initially the data was separated into sections of the survey related to the three different measures (cultural competency, behavioural change and psychological safety). Datasets that could not be linked were excluded from the analysis to allow for pre and post data examination of the validated measures. The analysis was descriptive and compared the pre-training and post-training responses using SPSS Version 30.0.

Analysis of the QI data

To enable real-time feedback to the programme team on data analysis of the QI experience questions, all respondent responses (i.e. meaning data were not exclusively paired) were initially used to understand all respondent experiences and reported levels of QI. This enabled real-time sharing of data via a dashboard with the programme team to help inform the delivery team approaches and response to training needs. Similarly to the previous section, descriptive analysis was used. However, for consistency paired data sets are reported in this evaluation report in line with the validated measures.

Table 2: Summary of data collection tools and time points

Domains	Measure / Source	When	N =
Demographic *(9 questions)*	Age, gender, ethnicity, nationality, role, length of service in role, full time or part time	Baseline (0 month)	n = 29 linked data sets n = 29 QI data sets
Cultural competence *(31 questions)*	Adapted from Cultural Competence Self-assessment Checklist. Central Vancouver Island Multicultural Society. (2012, September 19). https://www.cvims.org/.	0 and 6 months	n = 29 linked data sets
Behaviour change *(6 questions)*	Adapted from Keyworth, C., Epton, T., Goldthorpe, J., Calam, R., & Armitage, C. J. (2020). Acceptability, reliability, and validity of a brief measure of capabilities, opportunities, and motivations ("COM-B"). *British Journal of Health Psychology*, *25*(3), 474 – 501	0 and 6 months	n = 29 linked data sets
Psychological safety *(10 questions)*	adapted from: 04. PSAP. Measuring Psychological Safety. https://psychsafety.co.uk/	0 and 6 months	n = 29 linked data sets
Quality improvement *(14 questions)*	Internal non-validated measure	0 and 6 months	n = 29 unlinked data sets
Focus groups	Interview schedule with questions drawn from thematic areas linked to evaluation aims and objectives	6 months	n = 3
In-depth interviews	Interview schedule with questions drawn from thematic areas linked to evaluation aims and objectives and linked to the additional activities of the maternity champion roles	6 months	n = 5

Table 3: Cohort 2 attendance and response rates

ICB cohort	Number attending (maternity champions)	Pre-training measures completed	Post-training measures completed	Number of linked data sets (response rate)
Bristol, North Somerset and South Gloucestershire	n = 24 (4)	n = 19	n = 24	n = 13 (54%)
Bath, Swindon and Wiltshire	n = 19 (2)	n = 14	n = 4	n = 4 (21%)
Gloucestershire	n = 18 (1)	n = 19	n = 14	n = 12 (72%)

Evaluation governance

The project was registered for QI and evaluation purposes with the Quality and Safety Improvement team at North Bristol NHS Trust, and R&D offices for other participating sites where needed. NHS Research Ethics was not required.[f]

Oversight of how the evaluation was being conducted was delivered through the main programme board supporting the delivery at Health Innovation West of England. Documented valid informed consent was received from all training respondents at the first stage of the programme and revisited during later stages of the evaluation for those taking part in interviews and focus groups.

All data collection and storage were compliant with the Data Protection Act and General Data Protection Regulations with Health Innovation West of England following information governance policies set out by the Royal United Hospitals Bath NHS Foundation Trust.

Findings

The findings set out in this section are first reported quantitatively and then thematically, drawing on the triangulation of both quantitative and qualitative data generated through the TDF framework to help illustrate the insights generated. Pre and post training measures were collected, and only individual paired data sets were used in our analysis (n=29).

Quantitative cultural competency data

During the initial Black Maternity Matters pilot a theme emerged early on in our analysis after using a cultural competency measure at baseline. Respondents had self-rated their knowledge and skills before the course as ‘relatively high’ in all domains, which we had not anticipated. We hypothesised that respondents were displaying the Dunning-Kruger[40,41] effect; a cognitive bias that occurs when a person's lack of knowledge and skills in a certain area cause them to overestimate their own competence.

To moderate this hypothesised ‘over-estimation’ effect of the baseline, at the second measurement point (post-training) we asked staff to give two ratings, not just one. Having completed the training, we asked them to consider their baseline skills for a second time, but with the benefit of hindsight (retrospectively). We also asked them to rate their knowledge and skills having completed the course. In the pilot data (n=11) we were able to demonstrate the Dunning-Kruger effect of cognitive bias across 34 out of 36 areas of cultural competency. Staff had overrated their knowledge or skills at the start of the programme, and on completion of the training completion they were able to reflect on how little they had really known at the start.

[f] Identified by the Health Research Authority decision making tool: https://www.hra-decisiontools.org.uk/research/

To test if this cognitive bias was consistent, we replicated our data collection methods in the cohort 2 training programme when assessing cultural competency (as the main outcome of interest). Descriptive analysis of the data suggests that the Dunning-Kruger effect is repeated in areas of assessing cultural competency in cohort 2. A Likert scale was used for respondents to self-rate their perceived levels of cultural competency, and mean scores were calculated for each question. Tables 6 - 8 show the mean scores across the entire cohort (all three geographical regions). We calculated the percentage change between the two time points using the mean scores for each question. This is calculated twice; at the original baseline (T1) compared to the end of training (T2) and for a second time using the retrospective baseline (at T2) compared to the end of training (T2).

Across the majority of questions (28 out of 31 domains) in the cultural competency measure we found support for the Dunning-Kruger effect of over-estimation in knowledge, skills and awareness (Tables 6, 7 and 8). To be able to demonstrate this effect again is an important finding in the evaluation, as it illustrates that staff are over-estimating their social, cognitive and clinical skills to provide culturally competent care to racially minoritised women and birthers.

Our outcome data at the end of training demonstrates increased awareness, knowledge and skills in every domain in the cultural competency measure and this increases again when taking to account the Dunning-Kruger effect.

The next section on analysis of qualitative data adds to this insight by exploring further how the phenomenon is displayed and experienced in real-world settings and how our respondents reflected on this in relation to the impact of the anti-racist training.

Behaviour change and psychological safety data

Pre and post training behavioural change data is reported in Tables 4. The highest area supported for behaviour change can be seen in the increased levels of being psychologically able to implement anti-racist practice (22.8% increase), being motivated (18.1% increase) and physically able (14.7% increase). This suggests that the training is well placed to deliver outcomes in staff behaviour, which are related to mental wellbeing and performance that help preparedness to address racism.

However, there is less impact on 'opportunity' areas of the behaviour change domains such as the social opportunity (support from manager) which reports a 10.2% increase and physical opportunity (10.9% increase). Additional findings relating to enablers and barriers to QI implemented provide additional insight on why these opportunity areas may report lower.

In the behaviour change model, the highest rated question at baseline was respondents' motivation to implement anti-racist practice with a mean score 3.21 rising to 3.79 post-training. So, whilst it represents a high *percentage change* of the behaviour change domains (ranking second highest), perhaps more relevant, it indicates the high levels of staff motivation to address the issues of racism at the start of the programme.

There is a potential risk of bias in the self-selecting sample of staff who agree to attend the training and may be symptomatic of early adopters of change who are enthusiastic about new ideas and are willing to champion them, while late adopters are typically resistant to change and are the last to adopt[7]. Future scale and spread approaches for the programme may seek to take this into consideration.

The Black Maternity Matters training is not a specific 'team level' intervention and therefore it is perhaps not surprising to see less evidence of impact in the psychological safety data

[7] Diffusion of Innovation Theory

(Table 5). However, it may be more interesting in future work to further explore the domains for team safety showing lowest difference in anti-racist practice at work (feeling left out/rejected, feeling safe to take a risk on my team, working as a team to find the systemic cause) and to consider how these can be reflected in a behaviour change approach built within the programme delivery.

Table 4: *Pre and post behaviour change data (n=29 pairs)*

Behaviour change statement	Data Collection timepoint	Min Score (1-4)	Max Score (1-4)	Mean (1-4)	Std. Deviation	Percentage change between T1 and T2
I have the PHYSICAL opportunity to implement anti-racist practice at work (e.g. the necessary time or resources).	T1 baseline pre training	2	4	2.83	0.539	10.9%
	T2 post training	2	4	3.14	0.581	
I have the SOCIAL opportunity to implement anti-racist practice at work (e.g. good relationships with colleagues, support from manager).	T1 baseline pre training	1	4	3.03	0.566	10.2%
	T2 post training	2	4	3.34	0.553	
I am motivated to implement anti-racist practice at work (e.g. you desire or see the need to do this).	T1 baseline pre training	1	4	3.21	0.819	18.1%
	T2 post training	3	4	3.79	0.412	
Changing my behaviour to implement anti-racist practice at work is something that I do automatically (e.g. it happens without much thought)	T1 baseline pre training	1	4	2.76	0.689	12.3%
	T2 post training	2	4	3.1	0.489	
I am PHYSICALLY able to implement anti-racist practice at work (e.g. you have the physical stamina, strength or skill).	T1 baseline pre training	2	4	2.86	0.441	14.7%
	T2 post training	2	4	3.28	0.528	
I am PSYCHOLOGICALLY able to implement anti-racist practice at work (e.g. you have the right knowledge, interpersonal skills and cognition).	T1 baseline pre training	2	4	2.72	0.528	22.8%
	T2 post training	3	4	3.34	0.484	

Table 5: *Pre and post psychological safety data (n=29 pairs)*

Statement	Data collection timepoint	Min Score (1-4)	Max Score (1-4)	Mean (1-4)	Std. Deviation	Percentage change between T1 and T2
In my team, I understand what is expected of me.	T1 baseline pre training	1	4	3.03	0.82	10.2%
	T2 post training	2	4	3.34	0.61	
We value outcomes more than outputs or inputs, and nobody needs to “look busy”.	T1 baseline pre training	1	4	2.76	0.79	19.9%
	T2 post training	2	4	3.31	0.66	
If I make a mistake on my team, it is never held against me.	T1 baseline pre training	2	4	2.79	0.73	8.6%
	T2 post training	2	4	3.03	0.73	
When something goes wrong, we work as a team to find the systemic cause.	T1 baseline pre training	2	4	3.00	0.53	7.0%
	T2 post training	2	4	3.21	0.62	
All members of my team feel able to bring up problems and tough issues.	T1 baseline pre training	1	4	2.79	0.82	12.5%
	T2 post training	2	4	3.14	0.64	
Members of my team never reject others for being different and nobody is left out.	T1 baseline pre training	1	4	2.90	0.90	4.5%
	T2 post training	2	4	3.03	0.73	
It is safe for me to take a risk on my team.	T1 baseline pre training	2	4	2.90	0.49	6.9%
	T2 post training	2	4	3.10	0.62	
It is easy for me to ask other members of my team for help.	T1 baseline pre training	1	4	3.24	0.69	8.6%
	T2 post training	2	4	3.52	0.57	
Nobody on my team would deliberately act in a way that undermines my efforts.	T1 baseline pre training	1	4	2.97	0.73	10.4%
	T2 post training	2	4	3.28	0.65	
My unique skills and talents are valued and utilised in my work as part of my team.	T1 baseline pre training	1	4	2.93	0.70	15.3%
	T2 post training	2	4	3.38	0.56	

Table 6: *Cultural competency data [awareness domains] (n=29 pairs)*

Statement (awareness domains)	Data collection timepoint	Min Score (1-4)	Max Score (1-4)	Mean (1-4)	Std. Deviation	Percentage change between T1 and T2 post training	Percentage change between T1 baseline and T2 retrospective baseline	Percentage change between T2 retrospective baseline and T2 post training
I view human difference as positive and a cause for celebration. people of cultures different from my own	T1 baseline pre training	3	4	3.48	0.509	6%	- 9.7%	17.5%
	T2 retrospective baseline	2	4	3.14	0.639			
	T2 post training	3	4	3.69	0.471			
I am aware that in order to learn more about others I need to understand and be prepared to share my own culture.	T1 baseline pre training	2	4	3.07	0.593	10.1%	-15.6%	30.5%
	T2 retrospective baseline	1	4	2.59	0.733			
	T2 post training	2	4	3.38	0.622			
I am aware of my discomfort when I encounter differences in race, religion, sexual orientation, language, and/or ethnicity.	T1 baseline pre training	2	4	2.69	0.604	19.3%	-8.9%	31.0%
	T2 retrospective baseline	2	4	2.45	0.632			
	T2 post training	2	4	3.21	0.726			
I am aware of the assumptions that I hold about people of cultures different from my own	T1 baseline pre training	2	4	2.52	0.574	34.1%	-7.1%	44.4%
	T2 retrospective baseline	2	4	2.34	0.553			
	T2 post training	2	4	3.38	0.561			
I am aware of the stereotypes I hold as they arise and have developed personal strategies for reducing the harm they cause.	T1 baseline pre training	2	4	2.62	0.561	30.1%	-10.7%	45.7%
	T2 retrospective baseline	2	4	2.34	0.553			
	T2 post training	3	4	3.41	0.501			
I am aware of how my cultural perspective influences my judgement about what I deem to be 'appropriate', 'normal', or 'superior' behaviours, values, and communication styles	T1 baseline pre training	2	4	2.79	0.620	22.2%	-18.2%	49.5%
	T2 retrospective baseline	1	4	2.28	0.649			
	T2 post training	3	4	3.41	0.501			
I accept that in cross-cultural situations there can be uncertainty and that I might feel uncomfortable as a result. I accept that discomfort is part of my growth process.	T1 baseline pre training	2	4	2.90	0.557	26.2%	-14.5%	47.6%
	T2 retrospective baseline	2	3	2.48	0.509			
	T2 post training	3	4	3.66	0.484			
I intentionally make opportunities to put myself in places where I can learn about difference and establish diverse connections	T1 baseline pre training	2	4	2.55	0.736	35.3%	-8.2%	47.4%
	T2 retrospective baseline	1	4	2.34	0.670			
	T2 post training	3	4	3.45	0.506			
If I am a white person working with people racialised as Black, I recognise that I have inherently benefited from racial privilege, and may not be seen as safe, 'unbiased,' or as an ally.	T1 baseline pre training	2	4	3.12	0.600	21.1%	-32.0%	78.3%
	T2 retrospective baseline	1	4	2.12	0.881			
	T2 post training	3	4	3.78	0.422			
I'm aware of the impact of social context on the lives of culturally diverse populations, and how power, privilege, and social oppression influence their lives	T1 baseline pre training	2	4	2.97	0.566	17.2%	-27.9%	62.6%
	T2 retrospective baseline	1	3	2.14	0.693			
	T2 post training	3	4	3.48	0.509			

Table 7: *Cultural competency data [knowledge domains] (n=29 pairs)*

Statement (knowledge domains)	Data collection timepoint	Min Score (1-4)	Max Score (1-4)	Mean (1-4)	Std. Deviation	Percentage change between T1 and T2 post training	Percentage change between T1 baseline and T2 retrospective baseline	Percentage change between T2 retrospective baseline and T2 post training
I make mistakes and choose to learn from them	T1 baseline pre training	2	4	3.14	0.581	9.9%	-4.0%	15.0%
	T2 retrospective baseline	2	4	3.00	0.756			
	T2 post training	3	4	3.45	0.506			
I recognise that my knowledge of certain cultural groups is limited. I make an ongoing commitment to learn more through the lens of cultural groups that differ from my own	T1 baseline pre training	2	4	3.17	0.468	7.6%	-22.7%	39.2%
	T2 retrospective baseline	2	4	2.45	0.572			
	T2 post training	2	4	3.41	0.568			
I listen fully to answers and make the time to advance my knowledge from a variety of existing culturally diverse resources before asking additional questions. I do this so that I don't unduly burden members of marginalised communities	T1 baseline pre training	1	4	2.45	0.686	39.2%	-1.6%	41.5%
	T2 retrospective baseline	1	4	2.41	0.780			
	T2 post training	3	4	3.41	0.501			
I know that differences in race, culture, ethnicity etc. are important and valued parts of an individual's identity—I do not hide behind the claim of "colour blindness."	T1 baseline pre training	1	4	3.03	0.731	20.8%	-10.2%	34.5%
	T2 retrospective baseline	2	4	2.72	0.702			
	T2 post training	3	4	3.66	0.484			
I am knowledgeable about historical incidents and current day practices that demonstrate racism and exclusion towards those I label as 'others.'	T1 baseline pre training	1	3	2.17	0.539	53.9%	-3.2%	59.0%
	T2 retrospective baseline	1	4	2.10	0.557			
	T2 post training	2	4	3.34	0.553			
I recognise that achieving cultural competence and cultural humility involves a commitment to learning over a lifetime. I consistently demonstrate my commitment to this process.	T1 baseline pre training	2	4	2.93	0.704	22.5%	-15.3%	44.7%
	T2 retrospective baseline	1	4	2.48	0.688			
	T2 post training	3	4	3.59	0.501			
I recognise that stereotypical attitudes and discriminatory actions can dehumanise, even encourage violence against individuals because of their membership in groups that are different	T1 baseline pre training	3	4	3.34	0.484	12.6%	-15.3%	32.9%
	T2 retrospective baseline	2	4	2.83	0.602			
	T2 post training	3	4	3.76	0.435			
I continue to develop my capacity for assessing areas where there are gaps in my knowledge.	T1 baseline pre training	2	4	2.93	0.651	20.1%	-11.6%	35.9%
	T2 retrospective baseline	2	4	2.59	0.733			
	T2 post training	2	4	3.52	0.574			
I recognise that people have intersecting multiple identities drawn from race, gender identity, sexual orientation, religion, ethnicity, etc., and the potential influence of each of these identities varies from person to person	T1 baseline pre training	2	4	3.24	0.577	20.4%	0.0%	20.4%
	T2 retrospective baseline	3	4	3.24	0.435			
	T2 post training	3	4	3.90	0.310			
I'm aware that everyone has a "culture" and my own "culture" is not to be regarded as the singular or best point of reference to assess which behaviours are appropriate or inappropriate.	T1 baseline pre training	2	4	3.38	0.622	16.3%	-3.0%	19.8%
	T2 retrospective baseline	3	4	3.28	0.455			
	T2 post training	3	4	3.93	0.258			

Table 8: *Cultural competency data [skill domains] (n=29 pairs)*

Statement (skills domains)	Data collection timepoint	Min Score (1-4)	Max Score (1-4)	Mean (1-4)	Std. Deviation	Percentage change between T1 and T2 post training	Percentage change between T1 baseline and T2 retrospective baseline	Percentage change between T2 retrospective baseline and T2 post training
I develop ways to interact respectfully and effectively with individuals and groups that may differ from me.	T1 baseline pre training	2	4	2.97	0.499	14.8%	-7.1%	23.5%
	T2 retrospective baseline	2	4	2.76	0.577			
	T2 post training	3	4	3.41	0.501			
I effectively and consistently intervene when I observe others behaving in a racist and/or discriminatory manner.	T1 baseline pre training	1	4	2.45	0.632	32.2%	-8.6%	44.6%
	T2 retrospective baseline	1	3	2.24	0.636			
	T2 post training	2	4	3.24	0.511			
I adapt my communication style to effectively interact with people who communicate in ways that are different from my own.	T1 baseline pre training	2	4	2.90	0.557	21.4%	0.0%	21.4%
	T2 retrospective baseline	1	4	2.90	0.724			
	T2 post training	3	4	3.52	0.509			
I consistently seek out people who challenge me to increase my cross-cultural skills.	T1 baseline pre training	1	4	2.31	0.712	38.9%	-6.1%	47.9%
	T2 retrospective baseline	1	4	2.17	0.602			
	T2 post training	2	4	3.21	0.620			
I am actively involved in initiatives, small or big, that promote interaction and understanding among members of diverse groups.	T1 baseline pre training	1	4	2.31	0.712	37.2%	-9.1%	50.9%
	T2 retrospective baseline	1	4	2.10	0.900			
	T2 post training	1	4	3.17	0.711			
I consistently act in ways that demonstrate respect for the culture and beliefs of others.	T1 baseline pre training	2	4	2.97	0.626	20.9%	-6.7%	13.2%
	T2 retrospective baseline	2	4	3.17	0.602			
	T2 post training	3	4	3.59	0.501			
I learn about and put into practice the specific cultural protocols and practices that make me more effective in my work with diverse individuals and groups.	T1 baseline pre training	1	4	2.38	0.677	43.3%	-1.3%	41.5%
	T2 retrospective baseline	1	4	2.41	0.733			
	T2 post training	3	4	3.41	0.501			
My colleagues from different ethnic groups consider me an ally and know that I will support them in culturally appropriate ways.	T1 baseline pre training	1	4	2.62	0.728	26.3%	-1.1%	27.8%
	T2 retrospective baseline	1	4	2.59	0.780			
	T2 post training	2	4	3.31	0.604			
I work hard to understand the perspectives of others and consult with diverse colleagues and diverse resources about culturally respectful and appropriate courses of action.	T1 baseline pre training	2	4	2.79	0.559	23.6%	0.0%	23.6%
	T2 retrospective baseline	1	4	2.79	0.726			
	T2 post training	3	4	3.45	0.506			
I recognise my own cultural biases in a given situation and I'm aware not to set a bad example based on my biases	T1 baseline pre training	2	4	2.90	0.489	21.4%	-17.9%	47.9%
	T2 retrospective baseline	1	4	2.38	0.728			
	T2 post training	3	4	3.52	0.509			
I'm aware of within-group differences and I do not generalise a specific behaviour presented by an individual to the entire cultural community	T1 baseline pre training	2	4	2.93	0.704	18.8%	-5.8%	26.1%
	T2 retrospective baseline	2	4	2.76	0.689			
	T2 post training	3	4	3.48	0.509			

Qualitative data

Course attendance

Motivation to join

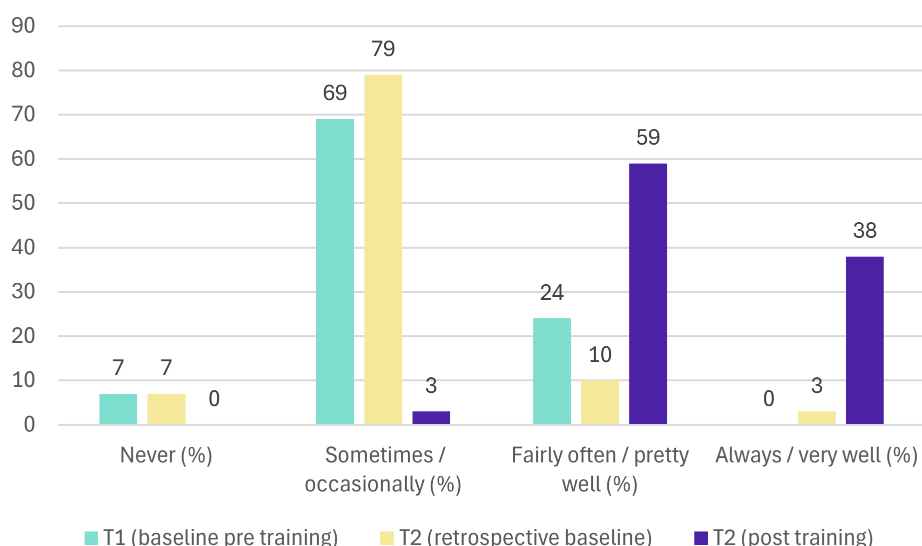
Domains associated with social influence and emotion from the theoretical domains framework (TDF) were thematically identified with individual motivation to join the training. Respondents reported different influences for wanting to join the training; some reflected on learning more to support their own personal views on anti-racism approaches, as well as how to respond in a professional setting. For others, they had experienced adverse professional events with patients that had left them with complex feelings from dealing with a personally significant event or work experience.

There was a clear narrative in data analysis that respondents are becoming increasingly aware of the health disparities faced by Black women and other racially minoritised groups, and recent high-profile reports, such as MBRRACE, have emphasised the increasing gaps in health inequalities for this group of women and birthers:

> *"I experienced a really poor outcome last December. I had a mum who came in for a planned C-section, looked me dead in the eye and said I'm four times more likely to die and I'm really scared of dying and and I had nothing to say to reassure her because it was true. And then her baby sadly passed away from an undiagnosed cardiac issue. So I was told there was nothing that could have been done differently. The care we provided was 'adequate'…. I used that term loosely. But I think there probably… even if not for that baby, there was more we could have done systemically in the NHS, cause she was very right in her fear, just not about herself. And that broke my heart into tiny pieces. So I wanted to fix it.* ***Speaker 7 FG02***

Alongside self-awareness of the impacts of health disparities, pre-training data (Figure 1) highlighted the trainees' lack of awareness of their own knowledge about historical incidents and current day practices that demonstrate racism and exclusion. Post-training knowledge levels increased, and it is proposed that this helped to strengthen the motivation of trainees to address issues of race and racism because they understood the historical context better.

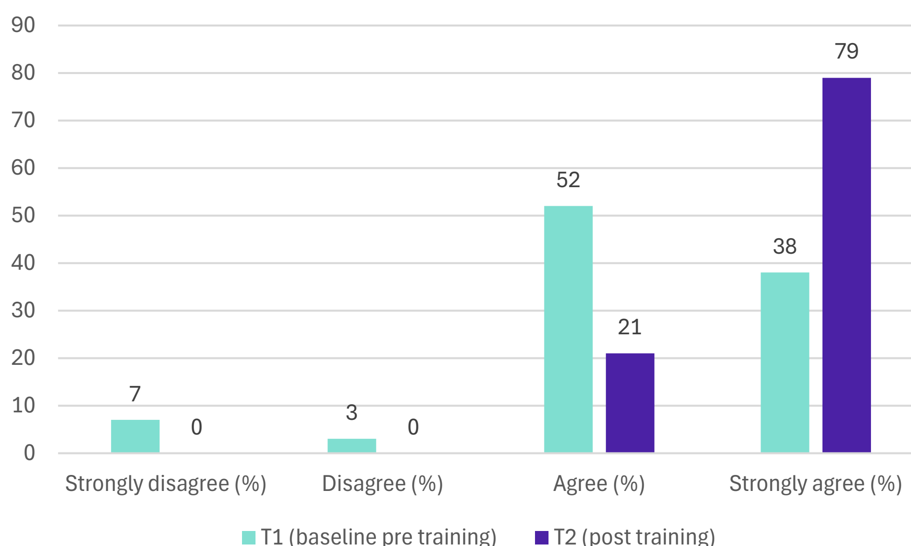
Figure 1: *CC.15. I am knowledgeable about historical incidents and current day practice which demonstrate racism and exclusion towards those I label as others*



Others were motivated by personal circumstance and experiences of social activism since the Covid-19 pandemic exposed the health inequalities experienced by racially minoritised groups on a global level, and behaviour change data (Figure 2) show an increase in motivation to implement anti-racist practice at work by the cohort.

> *"Yeah, well, when I I've only been in [X location] for just over a year now and when I was looking, I know they were doing the first cohort and it actually made me want to come here more because at my last Trust, they didn't do anything to do with it and I think from my own family background, we all work in EDI and unconscious bias and ethnicity in the workplace. So for me it's a very normal conversation…… I was like, I want to be part of something that does that, and it's got such a positive outlook especially after 2020 and Black Lives Matter, that was such an important conversation to have."* ***Speaker 10 FG01***

Figure 2: *BC.3. I am motivated to implement anti-racist practice at work*



Box 1: Course attendance: summary learning considerations

- Using insight from what has motivated this cohort, consider using the behaviour change principles of nudge theory to help encourage respondents to join this training. This might help attract those professionals who feel reluctant or are wary of attending the training.

- Highlight the motivations of others to help tackle health disparities in ethnic minority groups, and how this has led them to join this training.

Information planning and staff inclusion

Feedback about the ways in which staff received information about the training were mixed. Some respondents reported that they had received information, colleagues had talked about the course, and they felt well informed. Others noted that recruitment to the training hadn't made it clear who it was aimed at. Some felt it was only for midwives, so they had ignored emails with information:

“I put myself forward. I wasn't sure if I would be eligible because I was the maternity support worker, so I didn't think I was high enough level. I thought it wouldn't be relevant. They wouldn't want me in it. But then….I just. I put myself forward, partly because I've always been a staunch anti-racist and always been fighting, that always arguing with people about racism and highlighting things and I just I didn't want it to be a tick box exercise. I was very pleasantly surprised that it it's been pretty good.” ***Speaker 7 FG02***

“I actually didn't apply straight away. I saw the advert and I thought it looked really amazing, but I thought it was just midwives so I kind of like, I thought, I just sort of scrolled on by and then I think they put a little.. I think it was in a… an e-mail went out saying is there anyone interested? And I was like, can I? Cos I'm not a midwife. So I was like, can I do it? They were, yes, you can, and I was like brilliant… so…” ***Speaker 3 FG03***

In general, across the cohorts, it was reported that emails (for this professional group) are often not the best way to receive information, due to the volume they receive, and the limited amount of time staff have to spend at their desks taking in information:

“I was asked to come on the course, and I was asked to be the champion. Because there hadn't been any... from anyone that was racialised as Black or Brown, so I was apprehensive to start because I didn't know what it entailed. I've seen emails about it but just dismissed them because... I don't know why I just dismissed them, but I did. So it was like I just I guess… get rid rid of them all. And then I was asked to come on the course so I didn't know what it was going to entail when I didn't know what I had to do for the Trust.” ***Speaker 5 FG02***

Respondents reflected on the inclusion of manager roles in the cohort 2 training programmes (compared to the pilot which was for maternity support workers and midwives). The pilot data identified that managers and NHS leaders should attend anti-racist training to understand in full the issues and then be supportive of staff in their QI ideas and projects. This theme was replicated again in cohort 2. However, some respondents also felt that having managers in the same space as delivery workforce had the potential to change the dynamic of learning and the safe space of sharing. This highlights a common tension between workforce and management and should be taken into consideration in future cohorts:

I do also think depending on who the managers and things were that came. I don't know if I'd want to…be as…. like share as much. If if my you know, top managers were in here, I probably wouldn't be as open to some other things that I have been. ***Speaker 5 FG02***

But generally, the feedback highlighted that respondents felt the multidisciplinary style of staff inclusion to join the training created a greater opportunity to address maternity and neonatal care from a systems perspective. One suggestion included the idea of dedicated spaces set aside in the planning of future cohorts so different clinical expertise groups were offered spaces on the training, such as some for health visitors or neonatal intensive care unit (NICU) nurses and midwives:

“Even then we rarely get… you know, we won't get health visitors coming to our mandatory skills and drills, or NICU. So… and actually we all work really closely together and what's really lovely about this, is actually speaking to people from community and management and higher up because it then makes the ideas that you've got almost, I mean, I say ‘easier to implement’, but not in a lot of ways cos of

the systems but at least you know you get a different perspective from everybody and that's really helpful". ***Speaker 6 FG03***

Course planning needs to take into consideration the way different professional roles are hosted within an NHS, in particular for doctors in training who often rotate around different hospitals. This may make it harder for them to commit to the complete set of course dates, and this can act as barrier to enrolling:

> *"….some of the main barriers were not knowing if it was for you. So, the which.. which professional is it for and also just talking from doctor's perspectives…. we're both at posts where we stayed in the same, [yeah], Trust. So, we were able to commit to the timings whereas because it crossed rotation, for a lot of doctors, they move around between Trusts, so they weren't able to feel that they could sign up so.* ***Speaker 7 FG03***

Whilst it was acknowledged from a practical perspective that there may be logistical issues around scheduling a training course across the different speciality groups, it was also highlighted that there is an importance in having a multidisciplinary team approach (MDT) to training attendance, and that this 'framing' could also act as an enabler to encourage attendance from those less inclined or able to prioritise their attendance at this type of training. Whilst understanding who might best benefit from this training was not a specific evaluation objective, there may be some merit in additional work to understand the way different maternity teams interact and how this impacts culture or decision making. This, in turn, would help the programme team to understand who benefits most from this training, when and how it creates the desired system changes.

> *"I'd love to have more health visitors on. [Yeah]. That'd be great. Because… you know a lady has her baby And ten days later, two weeks later, she's transferred in to health visiting. And then we have them for five years. So yeah, I would love to have more health visitors on this. I mean I've I've started kind of just little disseminating little bits to different groups of staff, and it's just me, [states county] which is like huge. It feels huge but... yeah"* ***Speaker 1 FG03***
>
> *"I did want to say something just about the getting right people, the people that maybe wouldn't put themselves forward on the course because I think... I mean, I was really keen to get some Consultants on the course, but I think you've got to give them plenty of time and we only just really gave them a few weeks, and they need as much time as possible and that we could allocate some places, So I think it would be really good to get Consultants on this training course."* ***Speaker 8 FG03***

Speaker 8 goes on to invoke themes that speak to a work-based cultural difference between medical staff (i.e. consultant-based roles) and those in nursing and midwifery, which highlights the perceived differences in the power dynamics that often exist within hospital-based institutions:

> *"I think it's all types of people. So like we said we need you know.. people that just are working on the ground clinically. But we also need people who are in positions where they can influence big change you know. You can get your Consultants or if there is, if there are some cultural…. (women say ignorance), but…ermm…. d'you*

know what I mean… I think it would be good for them to be on board with this". ***Speaker 8 FG03***

Box 2: Learning considerations for information planning and staff inclusion

- Ensure course information explicitly articulates the training is open to maternity and neonatal staff from any NHS banding or role.

- Promote the course to consultant advanced nurse practitioners, and increase the recruitment of health visiting staff.

- Promoting and advertising the course via professional email routes has limited the engagement with the training offer. Consider additional ways to promote the course via face to face routes such as team meetings, staff Facebook groups, and newsletters.

- There is an ongoing need for trainers to be aware of the staff versus manager dynamic in course group sessions, and how this might impact engagement.

Course design and length

Respondents reported that the overall course design had enabled learning and reflection. The trainers were noted for their excellent style, knowledge, and ability to engage safely on an emotionally challenging topic. Respondents reported feeling safe and supported during their learning journey. Some felt that course length over six months enabled periods of reflection on the topics they had learnt, and this helped them to embed what they had learned back in their workplace, then bring these 'new' experiences back to the group for further reflection /discussion.

However, some respondents felt the gaps between each of the sessions was too long, and this was particularly noted for those staff who worked in smaller teams or who were lone workers and didn't have the additional time to talk or reflect with other colleagues at work. It was also noted that some additional form of psychological support for learners during the course could help address this between learning sessions:

> *Personally, I think over six months is just too much gaps in between. So you know when you talk about subject, which are very uncomfortable and people have to leave this… they will leave with that feeling of uncomfortableness and like we were talking about this morning about whether we should have like, psychology or somebody with you in session to support people who becomes upset because of some of the issues that we're discussing…"* ***Speaker 06 FG02***

Respondents reflect on how different this course has felt in comparison to previous anti-racist training approaches or courses. Data highlighted how some felt previous training was 'tokenistic' and this had made them wary of what the Black Maternity Matters programme might offer, and whether they wanted to attend or not:

> *"And the depths of the training that you get from this course in lots of things that I've done before, I have done types of anti-racism training or often labelled as 'equality, diversity, inclusion' training. But this goes so much deeper. It's so much more reflective and has the practical implications and encourages you to think about that right from the start. So I just think it is… this is not another anti racism training. This is different."* ***Speaker 07 FG03***

Box 3: Learning considerations for course length and design

- Check-ins across the six-month training period and have additional support resources / offers in-between sessions to ensure everyone feels connected to the programme, particularly lone workers or sole representatives from a team.

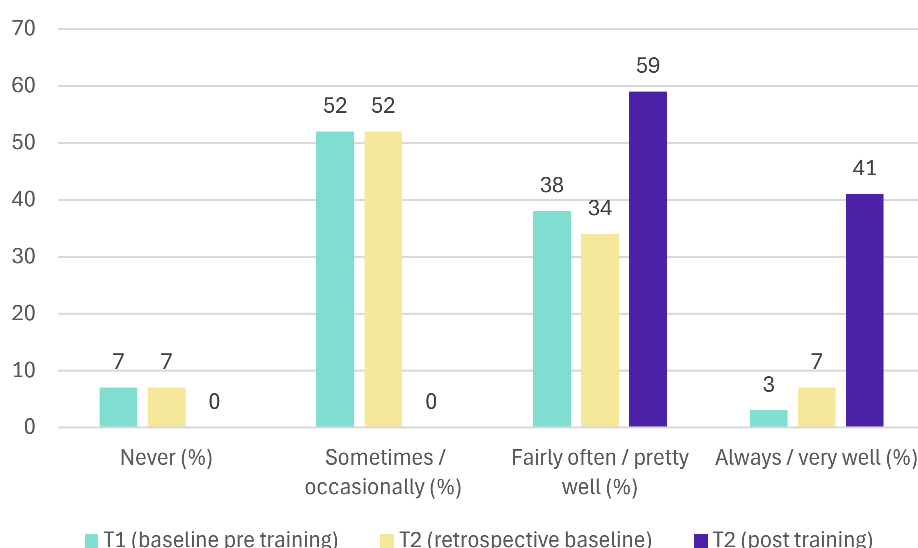
- Consider what additional resources might be needed to encourage embedded use of the WhatsApp group as a mechanism for peer support and connection.

- How can the role of the Maternity Champion be amplified to curate content and encourage participation through community building? What resources should be made available to those in this role to achieve that?

Transfer of knowledge and creation of skills

Respondent data invokes what can be described as an individual and unique ‘personal knowledge and learning’ journey around understanding racism in the work context. They reflected that the course content and trainers had allowed them to experience anti-racist training in a way that had not been received before. As noted earlier, previous experiences of training aimed at building cultural competence had not provided an innovative pedagogical method to understanding racism and its roots in UK history. In addition, trainees presented at baseline with low self-reported levels of learning and practice about specific cultural protocols or practices (Figure 3).

Figure 3: *CC.27. I learn about and put into practice the specific cultural protocols and practices that make me more effective in my work with diverse individuals and groups*



TDF domains associated with environmental context such as environmental stressors, resources and organisational climate were identified in the data as respondents described the broader issues of racism in healthcare institutions. Despite these apparent system-level barriers, adaptive behaviour to change personal practice was evidenced:

> *“Yeah. Also like for me on kind of it's on a more personal level like quite often working in the NHS can be like quite a frustrating place as a lot of systems that are working against you and what you're trying to achieve. One thing that I have felt through this training is that you're given kind of the skills and the knowledge to… on a*

personal individual level, to deliver, to be aware of issues that people might be facing and then to deliver a higher standard of care... Despite all the structural and systems problems that we face, because we've kind of spoken a lot about, it's about kind of trust and understanding and recognising the things that might have happened in the past that result in not wanting to access healthcare or being reluctant and actually then being like, OK well that's that. And on a personal level I can do this, despite being working in a system that's completely underfunded and under-resourced" ***Speaker 08 FG01***

Respondents reflected on the importance of dedicated space and time to undertake the training and how this allowed them to immerse themselves in content that was both challenging and progressive for their learning (Figure 4):

There's definitely a richness to the way this course is different. There are sort of so many… they bring in so many different elements… the book club, the quality improvement may be…. I can feedback on that. But the book club, the books, to read. You're…. it's immersive. Yeah, you're sort of completely immersing, we would never get that opportunity as health professionals to do that. And to have a whole day dedicated to just thinking about one thing when we're all multitasking, thinking of so many different things normally. It's… it's unique actually" ***Speaker 08 FG03***

Themes on knowledge gaps and avoidance of racism, as well as its traumatic and lasting impact on mothers and birthers, are identified by respondents and how this is not taught through any traditional educational curriculum or later professional training. The role of race and racism is often omitted from equality, diversity and inclusion training programmes (Figure 5). In the Black Maternity Matters training, knowledge and skills are developed and enhanced specifically because the curriculum offers in-depth learning on a topic that is often not part of a healthcare professionals' training:

"I think it's the way they've done it. Because in a way I I didn't know what to expect when I thought…I thought, 'OK, this is gonna go through midwifery symptoms and in Black and Brown people. And this is what mastitis looks like. And this…' I thought was very… because that's what you normally get. But actually its…. we're going to link it back to maternity, yes, but this is race. This is…. go to the fundamentals of the history and the knowledge and everything of how ….just go back and understand what race is in in the entirety, and then link it to maternity so you come out, even if.. on a personal level you've understood so much about yourself and the people around you, but also, how I can empower others at work?"

Figure 4: *BC6. I am psychologically able to implement anti-racist practice at work*

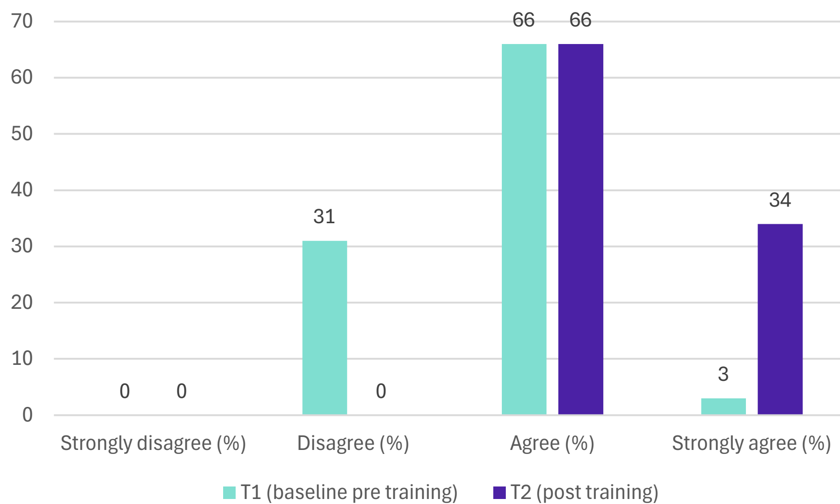
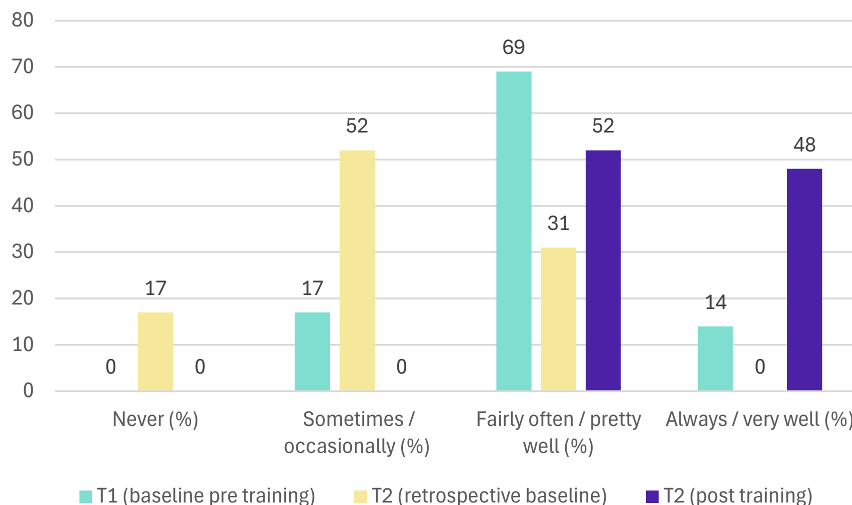


Figure 5: *CC10. I'm aware of the impact of social context on the lives of culturally diverse populations, and how power, privilege, and social oppression influence their lives*



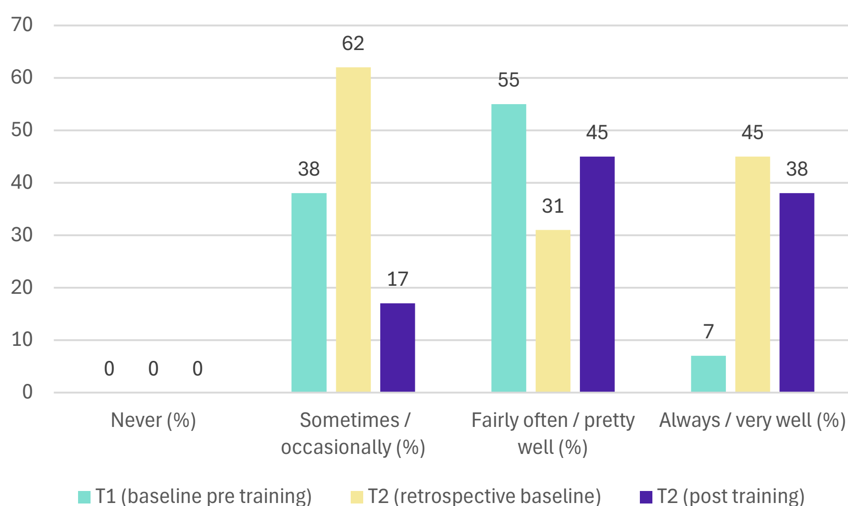
Discomfort during learning

A clear course identity and branding as anti-racism training was welcomed by the respondents who felt comfortable with the purpose and aims of the training, even though it might feel provocative, or even have the effect of putting people off at first:

> *"I think it should be called anti-racism training. I think that's the correct terminology. When I've spoken to people that I work with and said that that's what it is, they've said 'Oh my God' like that sounds really harsh the language but… maybe we might have thought it sounded a little bit harsh before we started the course? Maybe that's why."* ***Speaker 05 FG03***

> *"I do think it does encompass what this is about and like you said, anti-racism might seem quite provocative and confronting to people initially, but I think definitely like the Black Maternity Matters brand is quite something people can get on board with and feel they're able to ask questions about"* ***Speaker 07 FG03***

Figure 6: *CC3. I am aware of my discomfort when I encounter differences in race, religion, sexual orientation, language, and/or ethnicity*



Data highlighted the ways complex environmental context and social influences can affect respondent experiences. This could suggest psychological safety is necessary for respondents to experience as part of their group identity:

> *"So it felt like a good fit for you personally?* ***Interviewer***
>
> *"yeah, although at the time, I didn't realize. I mean, I've learned since…. and actually on the first day they said it's a great that it's room full of White women, but at the time I thought 'God, doesn't 'this' just represent that I'm going on Black Maternity Matters… kind of.. course. Because we have no representation'. Yeah, but now I realise, actually, that's a good thing. And that's fine because of the journey that we're all on."* ***Speaker 6 FG01***

During the Black Maternity Matters pilot project there was an exploration of historical and current experiences of racial bias, and respondents from the pilot cohort identified personal discomfort when learning truths about racism (Figure 6). Reactions to this discomfort differed; some found it inevitable and necessary for learning and growth, others find the discomfort to have an emotive or negatively emotive impact. This finding was replicated in cohort 2 trainees. The act of having to work through this discomfort to get to a place of acknowledging or accepting discomfort was identified as a gold thread to the programme. It also allowed respondents to 'examine' it and their response to it:

> *"I think I've enjoyed that aspect of it and learning to sit with my own discomfort. Yeah, So it has had like I've got like the the… discomfort, like physically sitting within me, but I've enjoyed that aspect of it, because I've come here to yeah, explore that in myself. So yeah, yeah.* ***Speaker 04 FG02***
>
> *Yeah, and learning about my own discomfort. It's not even something that you never would have thought that you had in the back of your mind.* ***Speaker 3 FG02***
>
> *Acknowledging it has been a bit like 'urgh, let's get rid of that. That's not nice'."* ***Speaker 1 FG02***

For some, the journey of learning about unconscious bias was more profound in their work practice, where the training has enabled them to become aware of work-based biases and how these might negatively impact health outcomes for Black women, birthers and their babies:

> *"I think mine's more work focused, but I think that I was more aware than I thought of my own biases in my life, but less aware of them within my work, if that makes sense.*

So like the systemic racism, constraints are much more impactful to me and highlight racism much more profoundly than anything in my private life does.” ***Speaker 04 FG02***

Our first report evaluating the Black Maternity Matters pilot identified themes about the need to confront bias in healthcare and how it relates to the health inequalities seen in national data. Throughout the training, respondents learnt about structural issues of racism. Data from cohort 2 shows that training enabled respondents to recognise they had previously dissociated their knowledge of health inequalities in the context of race; a theme that was also found in the pilot data. Respondents were also able to recognise institutional racism or poorer health outcomes for racially minoritised groups, and the training had done this in a way that meant they could not avoid or hide from these issues in their practice:

> *“I think you kind of know… stuff. But then you probably don't realise how bad it is and then now your eyes are open like they keep… they keep saying don't they, like, once your eyes are opened, you can't unsee things. And I think that’s kind of how you feel after doing this.”* ***Speaker 04 FG03***

> *“Just how entrenched it is in all of our systems… in the whole way that everything's been set up and it's…. I think that's one of the almost hardest things to unsee. Because actually once it's been pointed out to you, like well… of course, that is totally.. that is terrible the way it's being done, and that's why they're trying to make those changes is that much harder.”* ***Speaker 06 FG03***

The respondents noted that at times when difficult content was discussed, trainers had placed an emphasis (and importance) on self-care at the end of the sessions and this was felt to be important for all training respondents. However, it may have a different relevance for those of mixed heritage or those who are racially minoritised, and the concept of additional psychological support was considered a useful addition in future cohorts:

> *“And [trainer] in particular, … has reached out to me supported me through that as well, which goes beyond the scope probably of their job, but actually, like I said, it's like a community and so I think that has been a really important part of it. But I think it is important that that's factored in that for everyone you could experience... quite a lot of, like the overwhelming emotion as part of this and so that and they talked about potentially like psychological support or peer support ongoing and that potentially could be something that's factored into a new phase …”* ***Speaker 07 FG03***

Box 4: Learning considerations

- Discomfort during the learning process remains an outcome experienced by training respondents. The trainers are noted for their emphasis on self-care while learning. This places an importance of the skills required by those delivering this training to promote and maintain psychological safety during training, and support systems after.

- Consider the role of emotional support for respondents, how and when this could be offered to support people through their learning journey.

Increased confidence on talking about racism and its impacts

There was clear thematic evidence that the training had enabled respondents to see pathways within their practice to both act and behave differently with their new knowledge and confidence. This was described as 'having the right tools' to have better conversations both with other staff about why racism is a problem and with patients:

> *"…the growth and development makes you… like X just said, you think about... OK, awareness and how is the right way to broach this conversation? When do I need to step back and learn more so you don't just barge into a conversation and think I'm just gonna say 'ohh drop the racism word' and what's the quote they said... 400 years of history comes through the door. You can think about 'OK, how am I going to broach this? Is this the right way to do it? Do I just need to think? About this and go away'. It it's… I can't even think of the right word, but it is is so many levels of your kind of learning.* ***Speaker 7 FG03***

> *"I mean I found it… life changing. Absolutely life changing. And I I was coming from a point of feeling quite… quite knowledgeable and, but it has completely blown my mind and I probably couldn't even articulate the impact on an everyday level because I think the thing is that this issue is an everyday thing. And so yeah, and sometimes you… you don't know how it would have been without it, but you know, and the conversations I've had… the confidence that I've gained to, to talk about it."* ***Speaker 7 FG03***

There was recognition from respondents that their learning journey had only just begun and that as professionals delivering care, part of their continuing professional development included more personal research and self-learning on the topic areas in the training. They were able to demonstrate a self-awareness of needing to continue exploration of issues and how they will respond as part of sharing insight or creating change:

> *"And do you feel that your confidence is improved to go away and talk about this topic area more?* ***Interviewer***

> *Definitely [Yeah,] but with the caveat of I'm still not going to get it right every time, and occasionally there is probably areas where you think I'm gonna need to go away to do a little bit more research. Is that… or I think I sort of remember what they said, but I'll go back and have a look before launching."* ***Speaker 6 FG03***

TDF behaviour domains associated with optimism and professional role/identity were found in respondent responses to course design in mixing management staff with delivery staff. In

this second cohort this approach had the desired impact of helping all respondents to feel that creating change was within their power:

> *"It's very empowering. I think it was great that the programme has people from all different parts of the service that all grades of the service, so we have lots of very sort of high up manager and people in the program, but but you know, there's…. that everybody is represented and you do go away thinking that there is …. that I can make a change. A lot of our work you feel you're just a cog in a wheel and yeah you can't make a change….So that's, that's actually a really amazing thing to be part of. So it's very well though it's been quite an emotional program. It's very rewarding"* ***Speaker 8 FG01***

However, some data suggests that is still a need to support respondents following training, particularly those that, despite an increase in their personal knowledge and skills, would still not feel able to challenge colleagues perceived higher up in a healthcare hierarchy:

> *"I think those conversations are still difficult, [Speaker 11: Yeah, for sure] but like I don't feel like I've come out of this going 'oh I know… I know. I feel brave enough to question everyone over us' but me…but I would notice it. So it's I think it's it's on that next step but not on to that final step to actually….* ***Speaker 9 FG01***

Box 5: Learning considerations

- There is an opportunity in future cohorts to consider the power dynamics in intra-organisational roles. Ensure all respondents feel psychologically safe to share authentically on their personal learning journey without concern for management views.

- What else can be added to the training to help staff manage power dynamics in the workplace when addressing issues related to race and racism?

Book Clubs

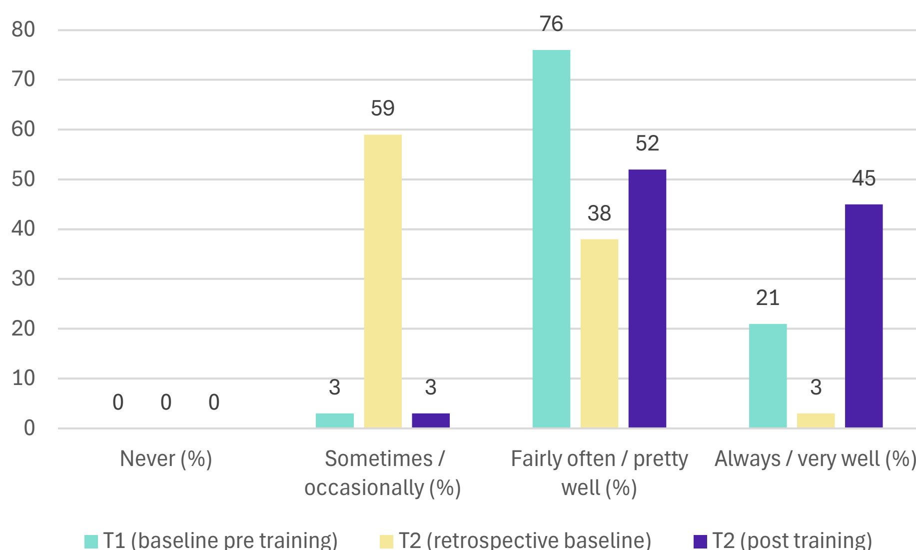
Respondents overall felt that the book club sessions added value to their learning on the course. These sessions provided dedicated and protected time to reflect on face-to-face learning and acted as keeping in touch days between the group in-person sessions.

> *"Like a keeping in touch day. Yeah. And I like that cos it kind of brings me… focuses me back. Otherwise it would be quite a big gap, between the face to faces, wouldn't it."* ***Speaker 3 FG02***

Several respondents reflected that the book Midwife Marley had not been as helpful a text as others in the programme and they had not been asked to put forward recommendations themselves, which might be a consideration for future cohorts.

> *"It's a really good book, like really informative. [I know you mean that, but yeah, no]. But it's just it's stuff as a midwife, I… like, it didn't bring me anything extra to the course because it's stuff that we know."* ***Speaker 3 FG02***

Figure 7: *CC12. I recognise that my knowledge of certain cultural groups is limited. I make an ongoing commitment to learn more through the lens of cultural groups that differ from my own*



Most noted that their own self-learning via personal reading lists had expanded since attending the course (Figure 7). Respondents talked about the books at work with colleagues and examples of continued shared learning was proposed by a midwife who planned to put her copy of Midwife Marley in the maternity unit waiting room, and another who planned to share it in the staff room so others could photocopy pages.

Book clubs were highlighted as a novel and effective mechanism to embed learning, which could be undertaken in the respondent's own time. The reading list provided had offered additional opportunity for learning that some may not have known existed.

> *"I just think the whole concept of the book club… this is the first type of study. I've done in, you know, when did I start, you know doing my training in various other you know, courses and stuff, it's the first time I've actually had the book club and I think it's I think I've learned a phenomenal amount from reading the books and they are books that I would not have picked up or took off a shelf or anyone who's ever recommended to me. So I I mean I I thought it was a really good addition to the study day to the face to face study stuff and that I learned a huge amount from the books."*
> ***Speaker 04, FG01***

Respondents who identified additional learning needs such as dyslexia, noted that reading books generally presented a challenge, particularly at pace between sessions. These respondents had made use of Audible subscriptions, but it is noted that this was not part of the training offer, leading to a possible inequity for some training respondents to this element of the programme, where they had paid for this themselves:

"But the thing about a book is you get all of the background about what brought somebody to that moment and that's what's really clever about them. I have to admit I'm dyslexic. So I am a really slow reader, so I've been very grateful that a couple of the books were on Audible. So I've used my Audible account to kind of listen to them." ***Speaker 06, FG01***

Box 6: Learning considerations

- Ask for book recommendations ahead of the training.

- Explore whether course respondents have additional learning needs, such as finding reading difficult (ie dyslexia). Can additional support be provided, such as audio books?

- Consider if Midwife Marley should be core reading for cohort 3 or added to an additional reading material list.

Quality improvement data

A locally developed measure of quality improvement (QI) experience was collected pre and post training to help inform the development and delivery of the QI training which was delivered alongside anti-racist training. Linked paired data is reported for 29 respondents. Over three quarters of respondents reported having undertaken QI activities prior to attending the Black Maternity Matters training programme (Figure 8). Confidence levels in understanding the meaning of QI in the context of health remained similar at the start of the programme when compared with the completion of training at month six (Figure 9).

Figure 8: *Have you ever undertaken any quality improvement activities, training, projects?*

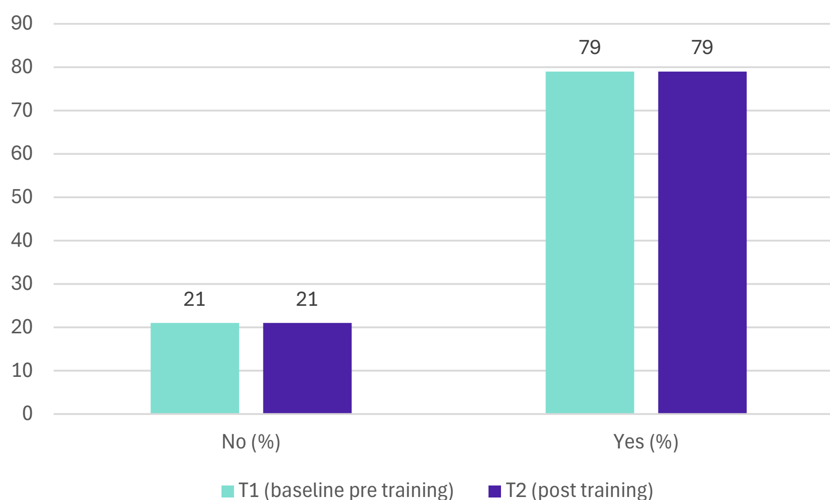
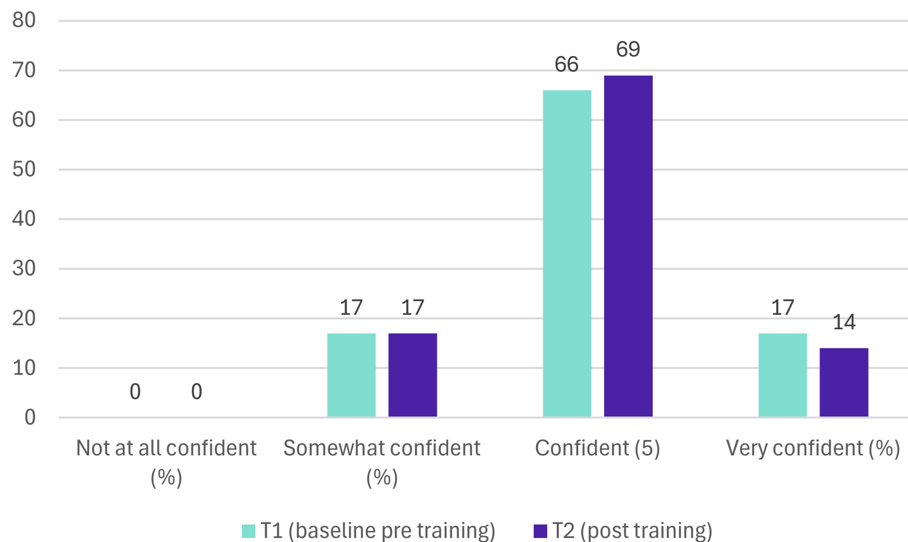
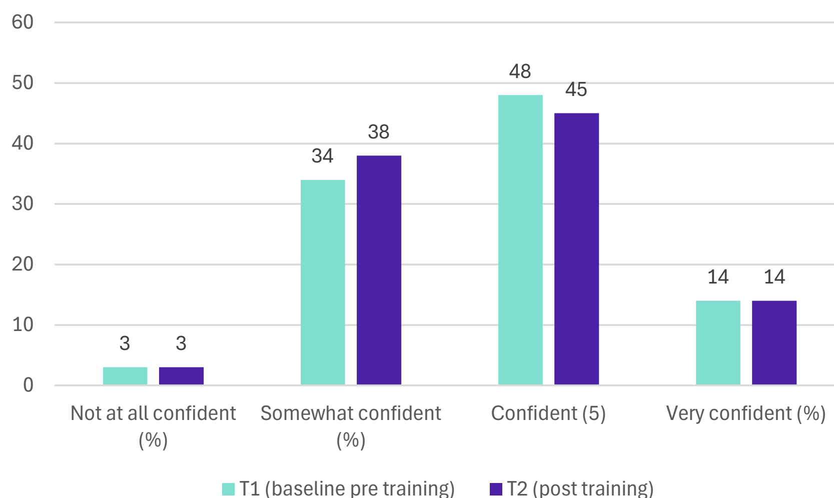


Figure 9: *How confident are you in your understanding of the meaning of 'quality improvement' in the context of healthcare?*



Low confidence levels in just over a third of respondents understanding of the range of QI methodologies were reported (Figure 10). These were marginally lower pre-training (37% not at all / somewhat confident) compared to post-training (41% not at all / somewhat confident). However, there was small number of staff within the sample for whom confidence levels reduced, and whilst most respondents post-training report 'mid-confidence' levels, this highlights the need to continue to support staff in their QI learning journey.

Figure 10: *How confident are you in your understanding of the range of quality improvement methodology and tools that are available?*



Data indicated that nearly all respondents felt that QI projects can make a significant difference to patient care (Figure 11). Therefore if confidence levels and skill can be increased in maternity staff, this has the potential to act as an enabler and accelerator for improving patient outcomes. Data from our training shows a very slight increase in respondents' confidence to implement a change to practice and test if it has worked (Figure 12).

Figure 11: *Please rate your agreement with the following statement "quality improvement projects can make a significant difference to patient care"*

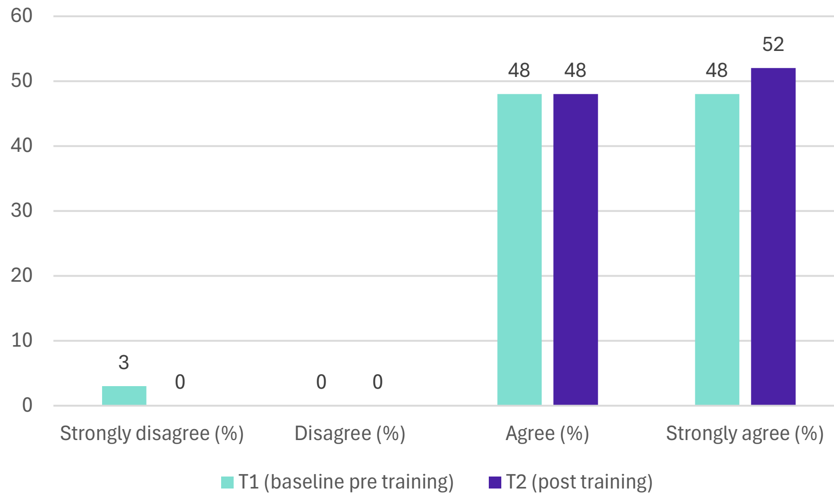


Figure 12: *How confident are you to implement a change to practice and test it to see if it has worked?*

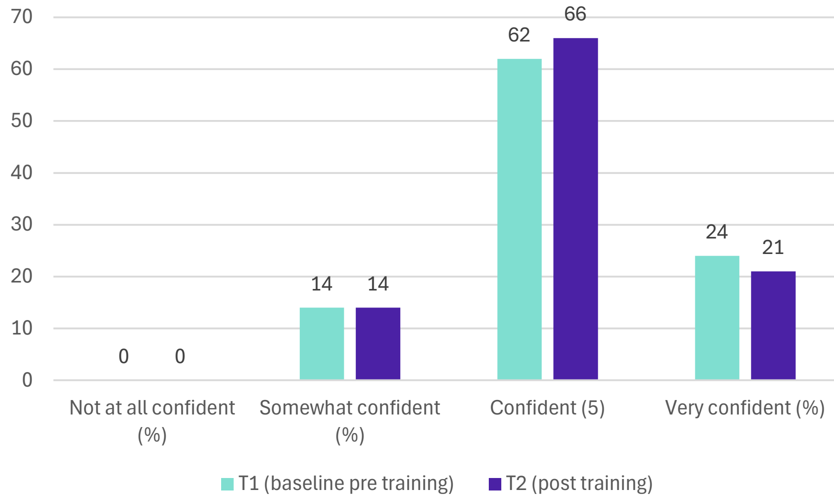
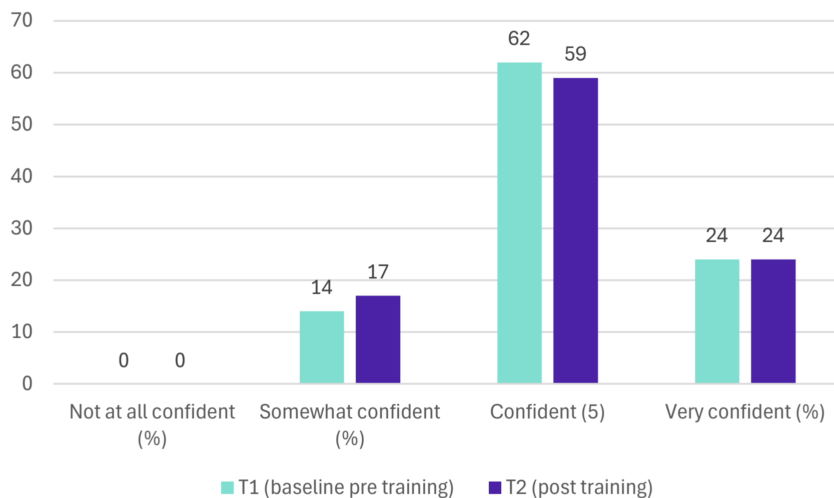


Figure 13: *How confident are you that you can improve care and the experiences of Black women, using maternity, obstetrics or neonatal care at your trust*



Self-efficacy (a measure of confidence in abilities and skills) and motivation are two important variables for professional learning. Our data shows respondent confidence levels to improve the care and experiences of Black women in maternity services through improvement approaches remains relatively static from pre to post training (Figure 13). This contrasts with the behaviour change data, which showed increased motivation levels to implement anti-racist practice at work (18.1% increase between T1 and T2 - Table 4).

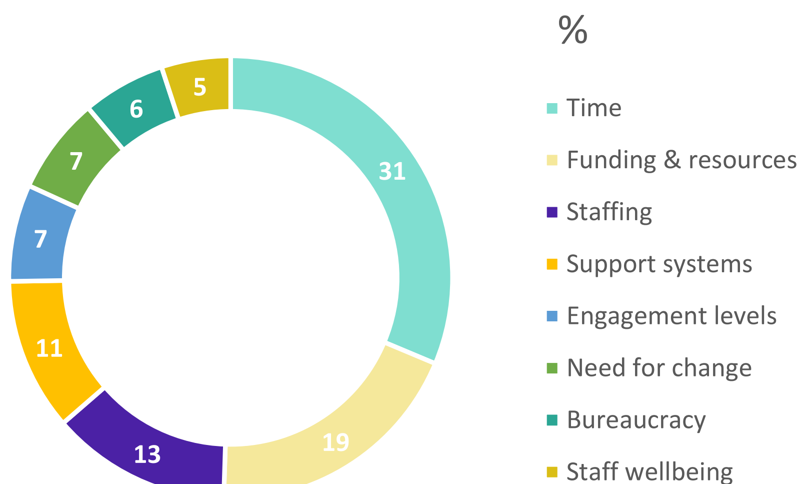
If self-efficacy is accepted as an important determinant of staff motivation and intention to pursue anti-racist practice, it will be important that staff confidence levels to carry out improvement activities continue to increase.

There is now an opportunity for the programme to develop a focus on domains such as social opportunity to implement anti-racist practice in maternity systems, where data suggests the lowest level of change (10.2% difference between T1 and T2 - Table 4), and to continue to address the confidence levels of staff.

Quality improvement training – mechanism for addressing change

Pre and post training respondents were asked to identify **barriers** to undertaking QI. In total, 18 pre-training and 19 post-training responses for this question were received and 127 different words associated with barriers. The majority of responses (31%) were words related to the theme around time available for staff to undertake QI (Figure 14). The second most common theme (19%) were words associated with funding and resources, and third highest with 13% were words describing barriers associated with staffing. Words or terms used were grouped into eight final categories according to 26 initial thematic codes (see Table 9 for how themes were created).

Figure 14: *Frequency of themes associated with barriers as described by respondents (%)*



When we asked respondents to identify **enablers** to undertaking QI, in total, 17 pre-training and 20 post-training responses for this question were received and 106 different words associated with enablers were identified. The majority of responses (26%) were words related to a theme for internal and external evidence which were perceived to drive or inform QI (see Figure 15). The second most common theme (25%) were words associated with staff culture. 17% of words were themed as external drivers in the third highest category. Words or terms used were grouped into six categories according to 34 initial thematic codes (see Table 10).

It is of interest to note that themes associated with staff shortages / lack of capacity to undertake QI rank second highest as a barrier, but are not identified as an enabler, where themes such as staff culture, teamwork and buy-in are described more as the enablers. However, staff time to undertake QI is identified as both a barrier (not enough time) and an enabler and offers important insight to the programme outcomes for sustaining change through QI.

Table 9: *Categories of words used to describe barriers to QI*

Themes	Categories of words used by respondents used to describe barriers to undertaking QI
Time	Protected time, lack of time, finding time, opportunity, making it a priority, time constraints, competing initiatives, implementing new digital systems
Staffing	Rotation of staff, sustaining change, staff shortages, staff lack capacity to engage
Funding & resources	Funding constraints, money, lack of support, resources, competing resources
Engagement levels	Lack of engagement, staff apathy, lack of investment from colleagues, staff fatigue, maintaining motivation and momentum
Staff wellbeing	Staff stress, burnout, headspace, mental energy, overwhelmed by clinical work, loss of enthusiasm, staff sickness
Support systems	Lack of support, poor leadership, poor manager support, feeling valued, reflective questioning perceived as negative, barrier to transformation, not feeling psychologically safe
Need for change	Resistance to change, all talk-no action, not a priority, lack of vision, lack of consensus by staff about how to change, individual bias
Bureaucracy	Needing a business case, bureaucratic red-tape, poor oversight, duplication, poor handover, needing manager approval / sign-off, one-size fits all approach

Figure 15: *Frequency of themes associated with barriers as described by respondents (%)*

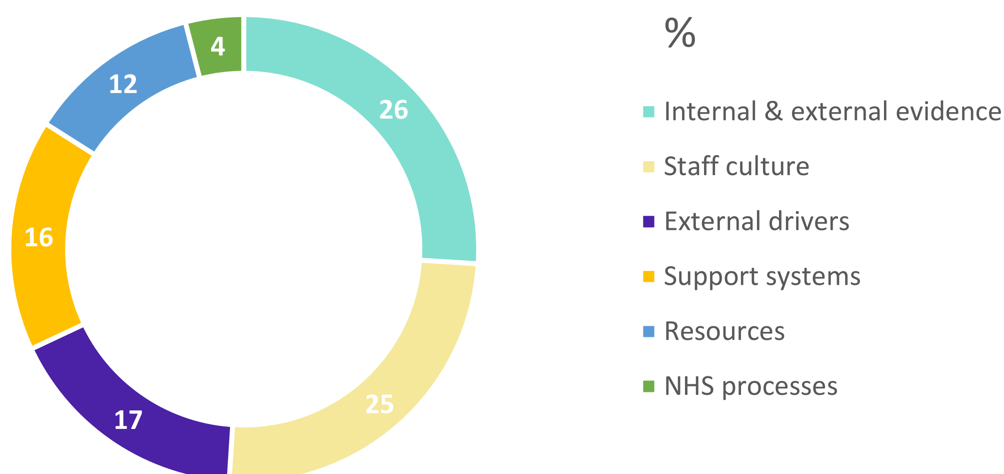


Table 10: *Categories of words used to describe enablers to QI*

Themes	Categories of words used by respondents used to describe enablers to undertaking QI
Internal & external evidence	Audit, routine data collection, patient feedback, family % friends test, staff feedback, mortality reviews, external reviews, Maternity Voices Partnership, evaluation, CQC data
Staff culture	Teamwork, time, buy-in, feeling valued, time to explore QI projects, celebration of QI projects, personal achievement in QI (empowerment / pride)
External drivers	National projects (PERIPrem), national agenda, policy documents, transformation agenda, network initiatives, community engagement
Support systems	Financial incentives, funding, psychological safety
Resources	Training for QI, resources, QI Academies, QI Hubs / huddles,
NHS processes	Governance, team meetings, patient safety team

The practicalities of fitting in the sessions

Some respondents felt that the time commitment for the QI aspect of the training programme had not been clearly described before committing to undertaking the training, and in this sense the QI learning at times felt like an additional pressure or burden on completing the course. For some this had its roots in the practicalities of childcare responsibilities. respondents had given up their time for the QI webinars and were often not paid for their time 'unless they chased' for it. For others, not knowing fully about the QI commitment meant they had not set aside enough time or the right personal learning environment at home to attend, complete the reading and think about designing a project:

> *"It's it's about childcare like I work 36 hours. I don't then have time to go home and sit down and read half a book and think about the next QI webinar. But if it had been outlined at the beginning, I might have gone OK that week I will set aside 4 hours or I'll get someone to have the kids so that I can read a bit of the book and make some notes for the next QI webinar."* ***Speaker 1 FG02***

> *"No, no. The QI project wasn't. I don't think it was made clear from the beginning. No. And that's a shame, because I feel that there's been there's months wasted, you know it. It's all clear now. Maybe like 3 months on because I had lots of conversations with some of the people who run the course and they made it very clear, crystal clear then, it felt for me... I felt, oh, God, I wish it was made clear from the beginning. And maybe it was, or maybe I misheard, but I could have started the QI project from the beginning or think about it then"* ***Speaker 6 FG02***

Some respondents articulated feelings of isolation to support their QI work, which were mostly related to working night shifts and feeling disconnected from support structures:

> *"It's finding time to discuss…. cos I'm working….. time for the QI project. You don't… I haven't been given any time by my manager to do it. And I'm working a lot of night shift, so I've got I can't discuss it with anybody because I'm on night shift and then I'm… all the QI webinars they clash with you with childcare... night shift. …I've been doing the book club and then going on night shift that night…. in the middle of when I should be sleeping and stuff. So yeah, it's just trying to fit it in when you're not aware that it's there, so….the QI project, I know what I want to do. And I've done a little bit of research, but because I'm on night shift constantly, I can't discuss it when I'm at*

work with people because there's only me and one midwife there and I can't discuss it any other time cause I've got childcare commitments so I'm a bit lost on the QA project at the moment. ***Speaker 7 FG02***

It was reflected by a number of respondents that aspects of the QI were expected to be delivered in their own time, yet still at their place of work. This highlights a tension for some of those in already pressured work environments, where it was felt that there should be more downward support from trust managers to enable QI activity. This reflects the need for a systems-based approach in the call to action / creation of change agents, and that staff need to be supported if they are to be successful in their endeavours to avoid 'change fatigue or burnout':

> *"I know you said like 'I wish I could want to this as well, for like no money' and it should be something we're all doing… but I feel like we're fixing the problems of like….. the government, no one else could be bothered to fix these systemic issues that's been put on us as an onus. Actually, I do feel like even though I would love to do this for free, our time is worthy of payment still, we're putting in our hard work and our Trusts are a bit…. it's more of a Trust thing than a than this course thing, but it is frustrating that, as you were saying, if you'd known about the QI projects in advance, perhaps we could have debated with the Trust to be like we're also having to put in X amount of time a week to do this reading and work on QI projects. What repayment could we have? But that's a conversation with our hospitals."* ***Speaker 4 FG02***

Some respondents describe a lack of trust or belief in the support from their employing trust,

> *"We've got a lot of QI projects in our team and I've chosen what I think is a fairly easy one and I've gone to the managers and said like, I would like XX [refers to a QI project idea]… for the Black ladies to come into the sections and was told like, 'no, there's no funding for that. Oh, unless another Trust is doing it, in which case we might have funding'. It's like, well, so you'll have funding if you're embarrassed, comparably embarrassed that you've sent us on this mission to try and reduce racism in the Trust. And then you've ticked that box, and now you're not supporting us any further with it. So again, that's not an issue with this course at all. That's an issue with the Trust, they're expecting us to make changes without actually implementing any funds any time or any support which is….* ***Speaker 4 FG02***

> *"I think even some… like XX [refers to a QI project idea] is a very, very, very small thing to ask for and even if that's the QI project and it's very achievable, we have funding for a lot of other things, [yeah]. And I think there's no one… What we need is someone in the Trust in management that we can go to and say that we've done this course. We're doing the QI project. I found you a really cost effective way to reduce racism ever so slightly, we need someone there to advocate for us as well, I feel like I've gone to all the managers and I'm getting a no from everywhere I go and then being told I have to provide my own funding for it and I'm like suddenly I'm doing charity works as well and actually, like I haven't got time with it.."* ***Speaker 4 FG02***

Some respondents reflected that QI training schedules had been inaccurate so not all respondents were able to join the sessions due to conflicting work schedules, and that emails to the project team were sometimes not responded to, leading to frustration, and highlighting the need for project team support across all the sessions.

> *"Also, I'd probably say my only criticism is the course itinerary we got at the beginning and was wrong, so the dates we were given the face to face dates and the book club were all wrong. So every time I refer back to the original listing, I thought we were on like a book club when we were on face to face and that's really messed*

around with my childcare issues and I've emailed a couple of times to say like here's a screenshot of my itinerary. Here's a screenshot of someone else's that I didn't receive, and they're different, so a lot of people weren't able to come to sessions like even today as I think is probably quieter because a lot of people thought it was the book club. And it still was... no one ever responded to that e-mail, and that was probably my only main frustration. [Yeah], is that actually we're trying really hard to put in time outside of work, which is already hard to then have that confusion." ***Speaker 4 FG02***

The test and learn approach to the Black Maternity Matters programme was well evidenced when some respondents describe the programme series not 'marrying up'. The internal programme team were able to respond to this feedback in real time and provide additional understanding about expectations and time needed for the course. For some this meant that they felt they had lost time in the learning process, but they had valued the support from the programme team:

"So it took me three months into the training…ermm to sort of…the QI project, the book club and the face to face, I… although they're all very relevant, it wasn't marrying up. There was lots of gaps in between. You know, as there was a a problem where there was a book clubs meant to be on. But it wasn't on and people were in online. It just wasn't marrying up. So I sent an e-mail on to XX and she was able to have that conversation with me very clearly made it very clear about what we're supposed to be doing then, you know. But I was three months on, so I'm always feeling like we're coming towards the end of the training. I thought, Oh no, I'm not quite ready yet. I want, I want more because I feel like I've lost the three months in. In the beginning. Yeah. So I'm really, it's great training, it is recommended, but it's a bit muddly." ***Speaker 8 FG02***

The QI training received mixed feedback at the start of the programme, in terms of content and tools used. A number of respondents reflected that they were unfamiliar with the methodology and the training session felt disconnected from the vision to create or deliver a QI project. This led to confusion about what was being asked, and some lacked confidence to undertake QI:

"I think an information sheet on what a QI project actually means would be… because I still I know what it means, but I don't know how to instigate it or how to prepare it. I've got I haven't got the tools because I haven't been to university to do midwifery, so I don't know if it's something that gets covered there. ….I went to one session and they talked about it. But I feel like if it was a document… you can do the session fine, but if you had a bit of paper that talked through it and told you what a QI project was, how you how you go about it, what you do and what you need to produce at the end of it like an outcome expectation." ***Speaker 7***

"I think using one from a previous cohort. Yeah, these people picked this. They decided to do it this way would be really helpful, [a case study] because then it also gives you jumping off ideas for the actual work projects. I think talking about it in such abstract forms was really confusing" ***Speaker 4 FGO2***

Box 7: Learning considerations

- Consider adding the QI online training sessions to the same day as book club to support scheduling of time.

- Take in to account the range of QI skills within the cohort and offer staged training sessions to meet individual needs, for example gold, silver, bronze level.

- Use theory where appropriate, keep sessions practical, showcase a maternity QI project to use as an example.

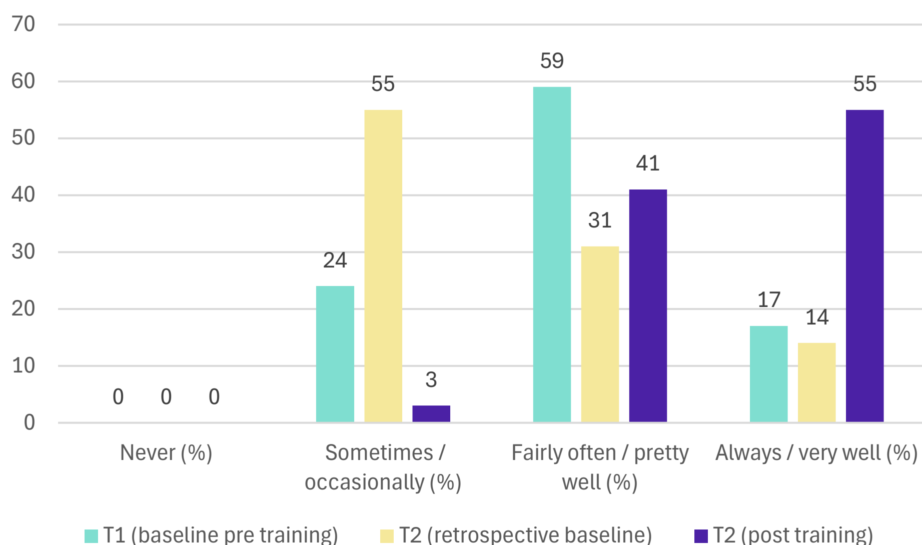
- Consider a session discussing the role of service improvement alongside QI, supporting those to create personal change that is right them and their professional role.

From theory to practice: creating action

Data revealed the different ways staff felt the training enabled them to evidence or demonstrate initiations of change or calls to action. A number were planning to share learning with their teams and felt the course had equipped them well with knowledge to share their learning about the impacts of racism. However, some expressed concern about having the confidence to share knowledge 'correctly'; they were still seeking support mechanisms from peers to help them with their transition to knowledge agents (Figure 16). These respondents were signposted to continued support from the Maternity Champions in their trusts, highlighting the need for the continuation of this role as a sustaining enabler once the training is complete:

> *"My team's keen for me to do a presentation and they just cannot wait, you know, they they, you know, they they need to, you know, kind of wait for the course to finish. For me then to present to the whole team. They have no idea. They know I go on this training, they have kind of…. know what it's about but they're just desperate and but my mind is like where do I start? D'you know what I mean?"* ***Speaker 06 FG02***

Figure 16: *CC18: I continue to develop my capacity for assessing areas where there are gaps in my knowledge.*



Some respondents shared examples of hearing colleagues questioning the need for the focus on health inequalities faced by Black women. They describe feeling more empowered to have discussions with these colleagues about why this is important (Figure 17):

> *"So I have been at work… there was a discussion about 'why are we referring Black people, why are we not referring people with …to the specialist midwife? Why are we not referring people who've got a language problem or [inaudible]? Yeah, it's it… And it's like it was literally just as I was leaving that day and like, OK, I'll tackle this when I'm back at X site, I will save that one for when I'm, but I'll have a big debate about it. And I.. I was like, clocked in my head which midwife said it and I will have that discussion when I get back there"* ***Speaker 07 FG02***

Others had been sharing insight about the course with colleagues from other professional groups and highlighted the need for a wider range of professionals from across the maternity and neonatal system to understand the issues of unconscious bias and racism:

> *"I was on a safeguarding course a few weeks back and there was I was on the table. There's a whole group of us, some different areas, and there was a paediatric doctor there and I was discussing the course and they were like asking questions to what, why is it relevant? And I was discussing it with them and they learned quite a lot just from what I was discussing with them and they they've been quite interested in doing the course afterward I discussed it with them"* ***Speaker 07 FG02***

Respondents shared examples of how new knowledge and skills, with increased confidence, had led them to have different conversations with patients aimed at understanding and providing better care. Behaviour domains associated with intentions (*a conscious decision to perform a behaviour or a resolve to act in a certain way*) were evident (Figure 18). One respondent explored patient trauma through a race lens and changed professional and personal behaviour as part of their response post-training:

> *"…. one of the experiences that I had was that I went to go and see a mum who had lots of birth trauma and post-natal depression. And I…. in the process of talking to her, I didn't I didn't put say 'ohh was race an element?' Because what I didn't want to do is it was... it's hard, isn't it?*
>
> *But I said 'Ohh, I've been doing this course called Black Maternity Matters and what I've been hearing about is...of stories about women who've experienced services and have found that these things happen, do you think that, you know, was that part of your trauma? Because from doing trauma work, I know that part of that is not being heard, not feeling in control. You know, those things rather than a a feeling, feelings of pain or or that it tends to be more about how you're acknowledged'… anyway, from that, she then opened up and from that I managed to connect her to the Black Mothers Matters groups.* ***Speaker 1, FG01***

Figure 17: *CC22 I develop ways to interact respectfully and effectively with individuals and groups that may differ from me.*

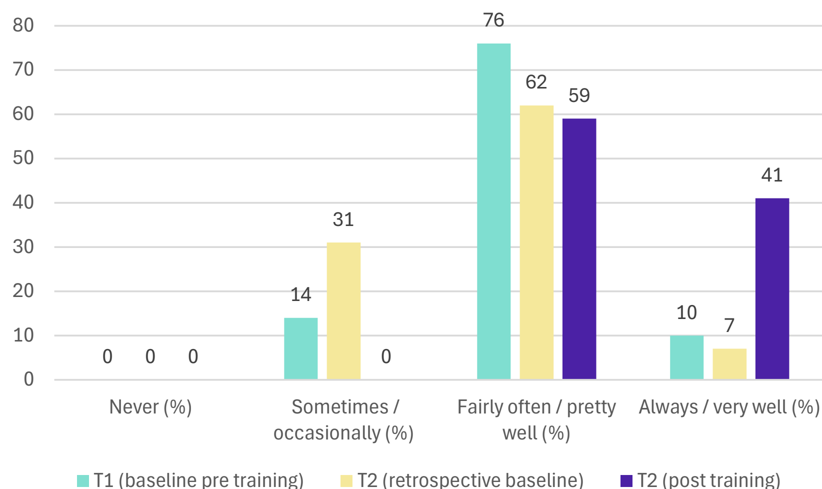
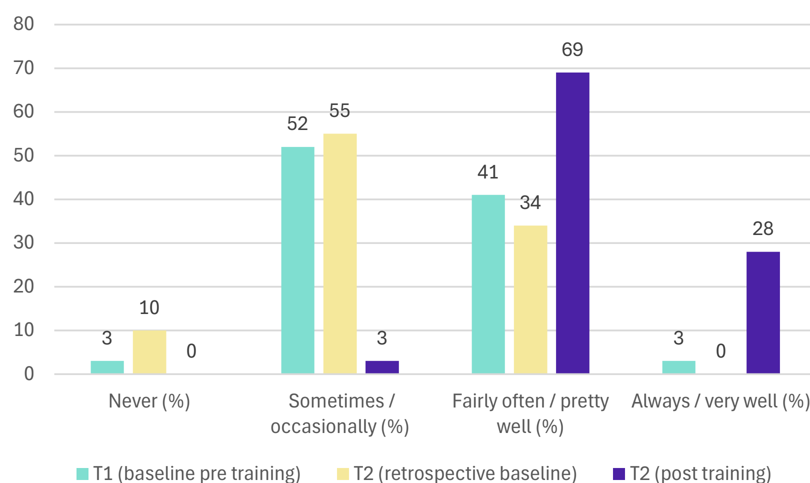


Figure 18*: I effectively and consistently intervene when I observe others behaving in a racist and/or discriminatory manner*



In respondent data associated with the TDF behaviour change domain for goals there was evidence of intention and mental representation of change following the training:

> *"This morning when we did a recap, people talked about the things they were doing. It's so inspiring like 'ohh that's achievable really'. And there's a lot of practical applications. So you often find with training, don't you that? They give you all these good ideas, but actually come away and you think. But what? What do I do now? How can I do something this I've got really strong feelings about this. This is so wrong. I wanna do something. But I don't know where to start. And that's not this. I feel like if anything I've got a list of loads of really easy wins, simple do tomorrow type things which is brilliant."* ***Speaker 06, FG01***

For staff who work in community settings there was frustration about the lack of additional resources to support Black mothers and birthers post-natally, or to signpost to other services that would understand their cultural needs. Respondents who worked in rural communities highlighted this as big gap in services for mothers and birthers, or those areas with poor

transport links, highlighting how this can add to health inequalities once someone is discharged from the care of health systems:

> *"I don't. There's not a lot. I don't think it's like preached about it or that it's not very, you know that you've got like breastfeeding post line, like cafes and stuff like that. But there's nothing specific to say 'this is a space for Black and Brown mothers, mothers that, if they want to go here, post-delivery antenatally easily, to be in a community where they've all are potentially experiencing the same type of thing. This is where you need to go to'. It's not signposted really anywhere, so I wouldn't be confident of knowing somewhere, but in the back of my head I might be thinking it but not being able to relay the information, cause I don't actually know it.*

Box 8: Learning considerations

- There is an opportunity to track implementation changes made by training respondents to help evidence and understand sustainability of the programme approach.
- What support systems are needed to help respondents create change back in their organisations and how will this be evidenced for impact?
- What broader system resource can be identified for mothers and birthers in local systems once they are discharged from health care systems?
- Consider the use of self-facilitated action learning sets or peer support networks to support sustainability of change.

Evaluation strengths and limitations

This was a real-world evaluation establishing the effectiveness of anti-racist training. Alongside this, the study gathered evidence of impact on staff, as well as drivers and barriers to implementing actionable change back in clinical settings. There is no meaningful comparison with a suitable control group that allows claims that this training is better than other options available. Respondents to our quantitative data were not a representative sample of the workforce and were a convenience sample who self-selected for our qualitative data approaches (focus groups and interviews). Therefore, the authors acknowledge the potential for a sampling bias, in that respondents taking part may have been influenced to take part by (for example) personal or professional interest in the topic area under discussion.

The quantitative approach was designed to provide a pre and post-intervention baseline within the maternity and neonatal workforce and offers robust evidence on the application and impact of the training provided on respondents' knowledge and skills. However, we have not sought to measure the impact of this training on outcomes at organisational level. There remains a need for further impact evaluation in this area to better understand how a culturally competent clinician can improve health outcomes both at individual and system level.

Data collection took place across three geographical areas in the West of England, covering both rural and urban areas and respondent attendance at training was multi-disciplinary. Both of these features add to the strength of the data collected as a characteristic sample of the maternity and neonatal workforce.

Discussion

Box 9: The King's Fund[42]

Race remains one of the most powerful organising ideas in our society, profoundly influencing people's chances in life, their experience of public services, and their health. And yet, it has no biological validity[43] and there is no gene or cluster of genes common to any so-called 'racial group'.

Instead, the idea of race has emerged as a political one, synchronised to the moral justifications of colonialism and slavery that are inherently linked with the distribution of power, resources and opportunities that maintain the inequities driven by it.

Sustainable change on racism is dependent on the abilities of health systems (and those within in them) to recognise and respond to those root causes which embed racialised belief systems, or shape responses to difference, and which are so often hard to face.

The national context highlighted earlier in this report has identified that whilst pregnancy in the UK remains safe, it is by no means equal. There are differences in maternity outcomes for women and their babies from different ethnic groups and those who live in more deprived areas, with a nearly four-fold difference in maternal mortality rates amongst women from Black ethnic backgrounds and an almost two-fold difference amongst women from Asian ethnic backgrounds compared to White women[3]. The Maternity Transformation Programme was launched by NHS England in 2016 and has led to the creation of Local Maternity and Neonatal Systems (LMNS) bringing providers and commissioners together to address these inequalities.

Yet despite clear policy direction, healthcare providers and their workforce have struggled to understand what the reality of institutional racism means for them professionally and personally. In response to this, the Black Maternity Matters programme has been co-designed and implemented using improvement methodology to address the gap in action, alongside the delivery of an anti-racist training programme in maternity and neonatal systems across the West of England to address the impacts of racism on women and birthers. Our evaluation has yielded important insights for the continued development of this programme and its transferability across the maternity and neonatal systems of healthcare providers.

Does the model for multi-disciplinary perinatal team training improve anti-racist competency (knowledge and skills) and practice (improvement in clinical settings)?

Our findings showed that maternity staff are becoming increasingly aware of the health disparities faced by Black women or birthers and other racially minoritised groups, as well as the recent high-profile reports (such as MBRRACE) that have emphasised the increasing gaps in health inequalities for these groups. Added to this, health inequalities which were exacerbated by the Covid-19 pandemic have helped to raise staff awareness and the importance of addressing their impacts. Pre and post training data has demonstrated that our anti-racist training has improved the awareness, knowledge and skills associated with anti-racist competency across the different maternity and neonatal staff groups in all 31 competency domains in the measure used.

The Dunning-Kruger effect (which occurs when a person's lack of knowledge and skills in a certain area cause them to overestimate their own competence[40]) emerged early on in our analysis of the initial pilot programme. In line with these findings, evaluation of cohort 2 data showed again that training respondents had overestimated their cultural competency and understanding of the impacts of racism at the start of the programme in 28 out of 31 competency domains. This links with the broader literature which suggests that individuals tend to underestimate their own levels of bias[40,41].

This repetition of the Dunning-Kruger effect presents important insight for the development and education of a national healthcare workforce, where knowledge of the impacts of racist practice may be known but there is limited cultural competence to counterbalance racist institutions[17,32]. To be able to demonstrate this effect again is an important finding in the evaluation, as it illustrates that staff are over-estimating their social, cognitive and clinical skills to provide culturally competent care to racially minoritised women and birthers. It highlights the need for programme work such as Black Maternity Matters to address these gaps in workforce cultural competence.

At the end of the training, respondents had increased their understanding of how racism contributes towards health inequalities and they were able to transfer this knowledge to their work context. The style and focus of learning on anti-racism has the potential to cause discomfort but was identified as part of a necessary journey. Creating a focus on anti-racism work led to an increase in understanding of the severity of the structural issues of racism and its consequences in healthcare. This training helped respondents improve key understanding, knowledge, and awareness of the impacts of racism, and has the potential to act as a catalyst for change of what can be done differently in healthcare spaces.

Does a multi-disciplinary perinatal team (a mix of operational and managerial staff) training approach better facilitate anti-racist competency and quality improvement practice?

Data from our pilot programme identified that managers and NHS leaders should attend anti-racist training to understand in full the issues, thus offering increased support to staff in their quality improvement ideas and projects. As such the training offer in cohort 2 was broadened out to include a range of maternity and neonatal staff (Appendix A3). The sentiment that anti-racist training should include healthcare system leaders to ensure that relevant and appropriate support could be made available to training respondents in their anti-racist practice was once again replicated again in cohort 2. This suggests that as staff become aware of systemic or institutional beliefs, their anti-racist practice might be 'limited' unless health system leaders can also act as enablers to change.

However, it was also identified that having managers in the same space as delivery workforce had the potential to change the dynamic of learning and the safe space of sharing. This highlights a common tension between workforce and management and should be taken into consideration when planning training approaches across the workforce. This will help ensure all staff are able to maximise their learning during training. There may be a need to develop specific managerial training for operational team leaders.

Overall, the multidisciplinary style of staff inclusion to join the training created a greater opportunity to address maternity and neonatal care from a systems perspective, shared learning, and facilitation of ideas. It was identified that there may be some merit in additional research to understand the way different maternity teams interact across the ante- and post-natal pathway and how this impacts culture or decision making. This, in turn, would help

system leaders to understand who benefits most from this training, when and how it creates the desired system changes.

We identified high motivation levels to implement anti-racist practice in this cohort at the start of the training, and there is a potential risk of bias in the self-selecting sample of staff who agree to attend the training. It is acknowledged that this may be symptomatic of early adopters of change who are enthusiastic about new ideas and are willing to champion them, while late adopters are typically resistant to change and are the last to adopt. Future scale and spread approaches for the programme may seek to take this into consideration when identifying system level approaches to address the impacts of racism, and to ensure that pockets of good anti-racist practice are not developed in isolation of wider workforce initiatives.

What is the impact of the programme on staff perceptions of psychological safety to practice and implement anti-racism in their place of work?

Data showed that the overall training design enabled learning and reflection. Respondents reported feeling safe and supported during their learning journey, and in particular the trainers' facilitation approaches, knowledge, and ability to engage safely on an emotionally challenging topic. This highlights the importance of the skill set of trainers to deliver a course for this duration and intensity, covering the topic areas both from lived experience but also with the professional expertise. Their ability to deliver content in a psychologically safe environment that allows respondents to experience the emotional safety needed to achieve the learning objectives (as engaged and activated learners) is essential.

Psychological safety data show an increase between baseline and end of training across all 10 domain areas, with the two highest reported for 'valuing outcomes more than inputs' (19.9% increase) and unique skills and talents valued and utilised within a team (15.3%). The lowest reported increases were seen in members of the team never rejecting others for being different (only a 4.5% increase) and feeling safe to take a risk on my team (6.9% increase) and working as a team to find a systemic cause when something goes wrong (7%). Future work may wish to explore the domains showing the lowest differences in psychological safety for anti-racist practice at work and consider how these can be reflected in a behaviour change approach that continue enhance psychological safety back within clinical settings once training is completed.

Data highlighted that finding and acknowledging discomfort during the training also allowed respondents to 'examine' it and their response to it in healthcare settings. Creating 'discomfort' in this way potentially acts as a moderator between self-knowledge and practicing anti-racism at work, by creating a learning or growth zone for professionals. This speaks to the complex environmental context and social influences that may hinder personal anti-racist practice in healthcare settings.

The trainers delivering this programme are experienced in delivering diversity, inclusion and anti-racist training across a number of different sectors, including education and healthcare. A synthesis of literature[44] suggests that three distinct areas of competency are commonly associated with and expected from effective anti-racism and diversity trainers (Box 10). Centrality of power relations is closely linked to concepts of psychological safety and is an important consideration when training the workforce to enact behaviour change for any intervention. This implies trainers need to have a clear sense of how these power dynamics operate in healthcare systems and their potential impact on racism in health equity.

Box 10: Specific core competencies of anti-racist and diversity trainers[44]

External knowledge: Trainers must have a solid knowledge base that equips them to challenge misinformation with fact-based content knowledge. They must possess a clear understanding of key terms and concepts, as well as the historical development and use of the notion of race and other power dynamics, both globally and in local legislative and policy contexts.

Internal knowledge and understanding: Effective trainers have an acute awareness of their own personal diversity issues, subject position and privilege, which allows them to help trainees navigate the difficult terrain of race, racism and diversity without being hindered by their own emotional triggers.

Group facilitation skills: Effective anti-racism and diversity trainers have the strong verbal and written communication and group discussion management skills required of all workplace trainers. More specifically, they are also competent at building and maintaining in-group trust and responding productively and appropriately to negative responses and/or behaviours that diversity and anti-racism trainees commonly display.

Has the quality improvement training improved the knowledge, skills and confidence levels in staff of improvement methodology approaches to address health disparities?

The use of quality improvement (QI) methodology as an integral part of the programme design was intended to deliver meaningful, actionable improvements to reduce inequity of outcomes for Black women within maternity systems through a collaborative quality improvement (QI) approach. Using PDSA cycles in this way can help deliver improvements in patient care through a structured experimental approach to learning and tests of change. Attendance at the QI training sessions was not mandatory for respondents and took into account that some staff may already have the prerequisite training, with just over three quarters reporting they had undertaken QI already (79% at baseline). We report marginally lower confidence levels in understanding the range of QI methodologies at the start of the training (37% not at all/ somewhat confident) compared to post-training (41% not at all/somewhat confident). However, there was small number of staff within the sample for whom confidence levels reduced, and whilst most respondents post-training report 'mid-confidence' levels (83%), this highlights the need to continue to support staff in their QI learning journey.

Whilst the multi-disciplinary perinatal team approach facilitated networking and enhanced learning, for some staff undertaking a QI project this felt isolating if they were the only ones representing their team or service, or worked night shifts. There remains significant practical pressures for this workforce group to practice QI, with some reporting the need to pursue their QI ideas in their own time, particularly due to clinical pressures. Our data highlights a number of helpful enablers to undertake QI, and these could usefully be promoted and highlighted within clinical settings to support staff.

This reflects the importance of a systems-based approach in the call to action / creation of change agents, and that staff need to be supported if they are to be successful in their endeavours to avoid 'change fatigue or burnout'. Yet, there was clear evidence of a number of different ways staff felt the training enabled them to evidence or demonstrate initiations of

change or calls to action. Respondents shared examples of how new knowledge and skills, with increased confidence, had led them to have different conversations with patients aimed understanding and providing better care.

What evidence is there of increased knowledge, skills and competencies translating into anti-racism action with NHS trust and community settings?

Our evaluation provides evidence that the training had enabled respondents to see pathways within their practice to both act and behave differently with their new knowledge and confidence. This was described as 'having the right tools' to have better conversations both with other staff about why this racism is a problem and with mothers and birthers.

Data showed that the learning journey for respondents had only just begun and that as professionals delivering care, part of their continuing professional development included more personal research and self-learning on the topic areas in the training; thus, suggesting there are no 'quick fixes' to the complex institutional contexts in which racism in healthcare exists. However, respondents were able to demonstrate a self-awareness of needing to continue exploring issues of race and how they will respond as part of sharing insight or creating change in their own settings. We report a 32.2% increase from baseline to post-training in staff reporting that they would intervene if they saw racist or discriminatory behaviour; increasing to a 44.6% change if we take in to account the Dunning-Kruger effect. We also see a 37.2% increase in staff reporting being actively involved in anti-racist initiatives (rising to 50.9% taking into account the Dunning-Kruger effect).

It is noted that issues of power dynamics and NHS hierarchy were highlighted as possible barriers to translating learning to action as some articulated they would still not feel able to challenge colleagues perceived higher up in a healthcare hierarchy. This raises considerations about what kind of support staff will need following completion of training to sustain and progress their anti-racist actions as change agents, and the role of senior leadership in building their own knowledge and skills to support improving cultural competence in the workforce. The Black Maternity Matters collaboration enables continued support and learning through communities of practice and seeks to address some of these issues.

Conclusion

Evaluation of the second training cohort of the Black Maternity Matters programme has demonstrated increased knowledge, skills and confidence for maternity and neonatal staff to both understand the impacts of racism and how it penetrates healthcare institutions. By offering a personalised and psychologically safe training environment, staff are taken on a learning journey that the majority have not been exposed to before in any stages of their education. The programme's bespoke components and work packages provide a framework for anti-racist practice and stands very differently from the existing race equity work often seen on offer within healthcare systems.

Achieving sustained and sustainable change on the impacts of racism depends on the abilities of those within healthcare systems to both recognise and respond to the root causes. Better knowledge and skills need to be transferred into actionable change; by offering embedded QI approaches and support, staff are given the tools by which they can begin to address racism in their work. In adopting a complexity mindset, the programme has continued to respond to feedback and evolved in its design to avoid binary or reductive thinking with simplistic toolkits or tick box projects. The programme has demonstrated that it offers collaboration, experimentation, and learning.

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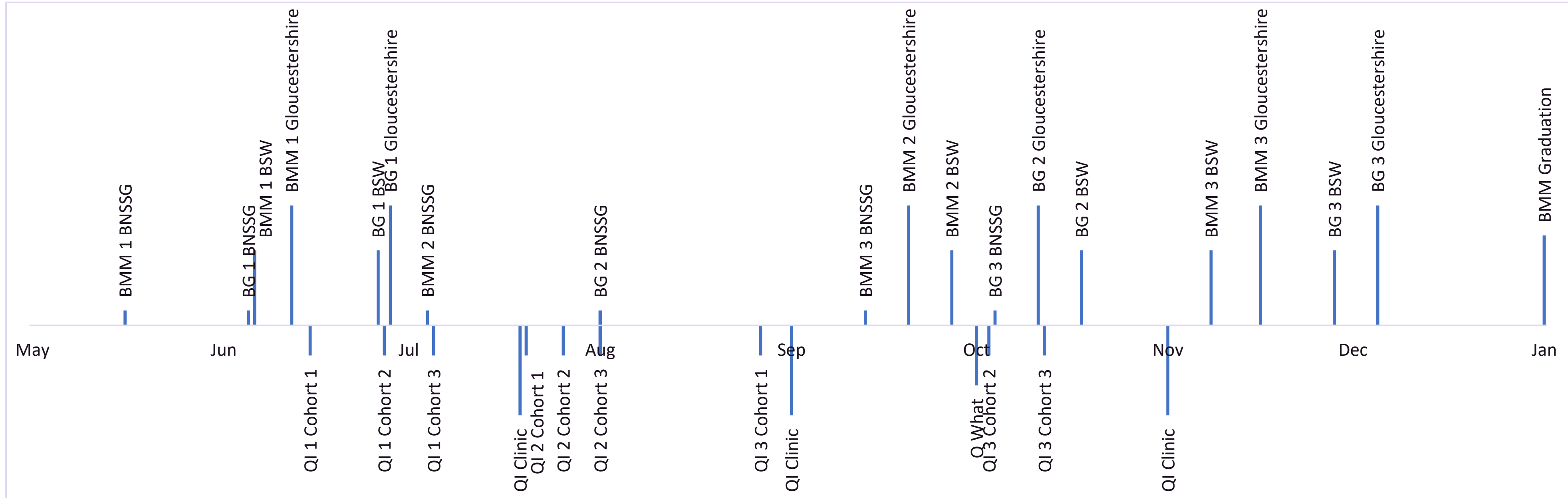
Appendices

A1: Timeline of the programme components for cohort 2 (2023/24)



A2: The refined Theoretical Domains Framework

Domain/Definition*	Constructs		Used within the evaluation
Knowledge *An awareness of the existence of something*	- Knowledge (including knowledge of condition/scientific rationale) - Procedural knowledge	- Knowledge of task environment	✓
Skills *An ability or proficiency acquired through practice*	- Skills - Skills development - Competence - Ability	- Interpersonal skills - Practice - Skills assessment	✓
Social/Professional Role and Identity *A coherent set of behaviours and displayed personal qualities of an individual in a social or work setting*	- Professional Identity - Professional role - Social Identity - Professional boundaries - Professional confidence	- Group identity - Leadership - Organisational commitment	✓
Beliefs about Capabilities *Acceptance of the truth, reality or validity about an ability, talent, or facility that a person can put to constructive use*	- Self-confidence - Perceived competence - Self-efficacy - Perceived behavioural control - Beliefs	- Self-esteem - Empowerment - Professional confidence	✓
Optimism *The confidence that things will happen for the best or that desired goals will be attained*	- Optimism - Pessimism - Unrealistic optimism	- Identity	✗
Beliefs about Consequences *Acceptance of the truth, reality, or validity about outcomes of a behaviour in a given situation*	- Beliefs - Outcome expectancies - Characteristic of outcome expectancies	- Anticipated regret - Consequents	✓
Reinforcement *Increasing the probability of a response by arranging a dependent relationship, or contingency, between the response and a given stimulus*	- Rewards (proximal/distal, valued/not valued, probably/improbable) - Incentives - Punishment - Consequents	- Reinforcement - Contingencies - Sanctions	✗
Intentions *A conscious decision to perform a behaviour or a resolve to act in a certain way*	- Stability of intentions - Stages of change model	- Transtheoretical model and stages of change	✓
Goals *Mental representations of outcomes or end states that an individual wants to achieve*	- Goals (distal/proximal) - Goal priority - Goal/target setting - Goals (autonomous/controlled)	- Action planning - Implementation intention	✓
Memory, Attention and Decision Processes *The ability to retain information, focus selectively on aspects of the environment and choose between two or more alternatives*	- Memory - Attention - Attention control	- Decision making - Cognitive overload/tiredness	✓
Environmental Context and Resources *Any circumstance of a persons' situation or environment that discourages or encourages the development of skills and abilities, independence, social competence, and adaptive behaviour*	- Environmental stressors - Resources/material resources - Organisational culture/climate - Salient events/critical incidents	- Person x environmental interaction - Barriers and facilitators	✓
Social influences *Those interpersonal processes that can cause individuals to change their thoughts, feelings or behaviours*	- Social pressure - Social norms - Group conformity - Social comparisons - Group norms - Social support	- Power - Intergroup conflict - Alienation - Group identity - Modelling	✓
Emotion *A complex reaction pattern, involving experiential, behavioural, and physiological elements, by which the individual attempts to deal with a personally significant matter or event*	- Fear - Anxiety - Affect - Stress	- Depression - Positive/negative affect - Burn-out	✓
Behavioural Regulation *Anything aimed at managing or changing objectively observed or measured actions*	- Self-monitoring - Breaking habit	- Action planning	✓

*All definitions are based on definitions from the American Psychological Associations' Dictionary of Psychology (Washington: 2007)

A3: Cohort 2 demographic data (n=29)

Table 1: demographic data by age (n=29)

Age (years)	Number	Percentage
25-34 years old	11	38%
35-44 years old	7	24%
45-54 years old	5	17%
55-64 years old	6	21%
Total	29	100%

Table 2: demographic data by ethnicity (n=29)

Ethnicity	Number	Percentage
White, White British	23	79%
Multiple or mixed ethnic group	2	7%
Black, Black British, Caribbean or African	2	7%
Asian or Asian British	1	3%
Other ethnic group	1	3%
Total	29	100%

Table 3: demographic data by age (n=29)

Occupation	Number	Percentage
Midwife	15	52%
Other	9	31%
Health Visitor	1	3%
Maternity Support Worker	2	7%
Consultant	2	7%
Total	29	1000%

Table 4: demographic data by length of service (n=29)

Length of service	Number	Percentage
More than 3 years	16	55%
1 - 3 years	8	28%
6-12 months	2	7%
Less than 6 months	3	10%
Total	29	100%

Table 5: demographic data by gender (n=29)

Gender	Number	Percentage
Female	29	100%
Male	0	0%
Total	29	100%

A4: Use of language in this report

Guidance on writing about ethnicity was taken from the Government website[8]. In line with the guidance, we do not use the terms BAME (Black, Asian and minority ethnic) and BME (Black and minority ethnic).

Throughout this document we have used the term ‘racially minoritised’ when talking about people who are not racialised on sight as White British. This is to ensure the distinction between ethnicity and race, and to recognise that whilst race is a social construct, the way that people are racialised by others causes individuals and groups to be treated differently and to experience a range of inequalities and poor outcomes as a result.

Race

A social construct used to categorise groups of people, usually based on perceived physical characteristics or shared ancestry.

Racialised categorisations may have characteristics associated with them that have no biological basis, and they have fuelled discrimination, violence and global power imbalances for centuries.

However, we recognise that racial identity is important to some people and can provide a way for marginalised groups to collectively share support, build community, or protest and tackle prejudice.

Ethnicity

A term used to describe a social group with a shared cultural identity, which may include language, traditions, geographic origin, religion, cultural expression or customs.

An ethnic group can often be chosen by an individual, as opposed to a race, which is often ascribed to a person or group without their input.

[8] https://www.ethnicity-facts-figures.service.gov.uk/style-guide/writing-about-ethnicity/

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