Health Innovation West of England

Executive Summary:

Evaluation of the Black Maternity Matters Programme (Cohort 2)

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

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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.

A core component of the pilot was the delivery of an anti-racist training programme for midwives and maternity support workers (MSWs) alongside a quality improvement (QI) collaborative. The training 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 trainees to co-produce and implement small tests of change aimed at optimising outcomes for Black women within maternity systems. Our pilot evaluation can be found here. This executive summary shares findings from the second phase of delivery (cohort 2), which ran during 2023.

The national context

Analysis of maternal deaths, stillbirths and neonatal deaths undertaken by 'Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries' across the UK showed that poor outcomes are higher for mothers 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 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.

Specifically for Black and Asian women and birthers, unconscious bias, stereotyping and lack of diversity competency all have the potential to result in health services that disadvantage those from racially minoritised backgrounds. The barrier to equitable healthcare arising from racism, has led to the identification of cultural-specific support and anti-racist training for healthcare professionals as an area of interest in addressing the healthcare inequalities that some women face in maternity systems.

The Black Maternity Matters cohort 2 intervention

The anti-racist training programme in cohort 2 was delivered over a six-month period. It comprised 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). QI training was delivered online during the six-months. The training was open to a range of staff from across the maternity system and 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.

Evaluation aims

An independent mixed-methods evaluation was undertaken to understand the impact of the programme components to deliver improvement in the outcomes for Black mothers and birthers 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. Specific evaluation questions were designed to better understand the programme impact.

Findings

The findings are reported quantitatively and then thematically, drawing on the triangulation of both quantitative and qualitative data. 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, the Dunning-Kruger effect emerged; 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 test if this cognitive bias was consistent, we replicated our data collection methods in the cohort 2 training programme when assessing cultural competency. 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. 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.

Behaviour change and psychological safety data

The highest area supported for behaviour change was seen in the increased levels of being psychologically able to implement anti-racist practice (22.8% increase), being motivated (18.1%) and being 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. 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), it does indicate the high levels of staff motivation to address the issues of racism at the start of the programme.

Course attendance: motivation to join

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***

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 the 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. Respondents reflect on how different this course has felt in comparison to previous anti-racist training approaches or courses, which had felt 'tokenistic':

> *"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***

Transfer of knowledge and creation of skills

Respondents describe 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. They described the broader issues of racism in healthcare institutions, but despite these apparent system-level barriers, adaptive behaviour to change their personal practice was evidenced.

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. The training covers an exploration of historical and current experiences of racial bias, and respondents identified personal discomfort when learning truths about racism. 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.

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.

Increased confidence on talking about racism and its impacts

There was clear 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:

> *"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.

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. Most noted that their own self-learning via personal reading lists had expanded since attending the course. 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.

Quality improvement data

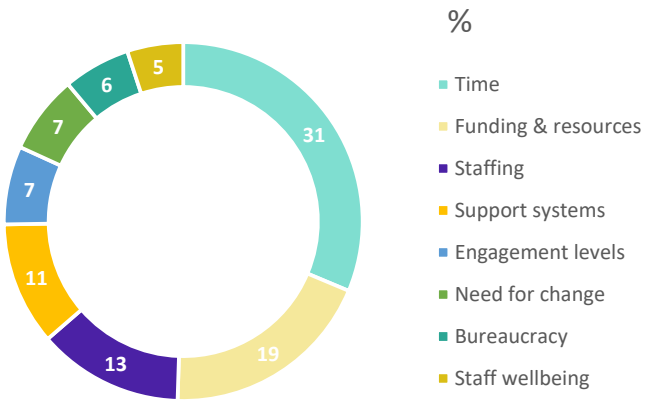
Over three quarters of respondents reported having undertaken QI activities prior to attending the Black Maternity Matters training programme. Confidence levels in understanding the meaning of QI in the context of health remained similar at the start of the programme when compared with the completion of training at month six. Low confidence levels in just over a third of respondents' understanding of the range of QI methodologies were reported.

Data indicated that nearly all respondents felt that QI projects can make a significant difference to patient care, 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.

Quality improvement training – mechanism for addressing change

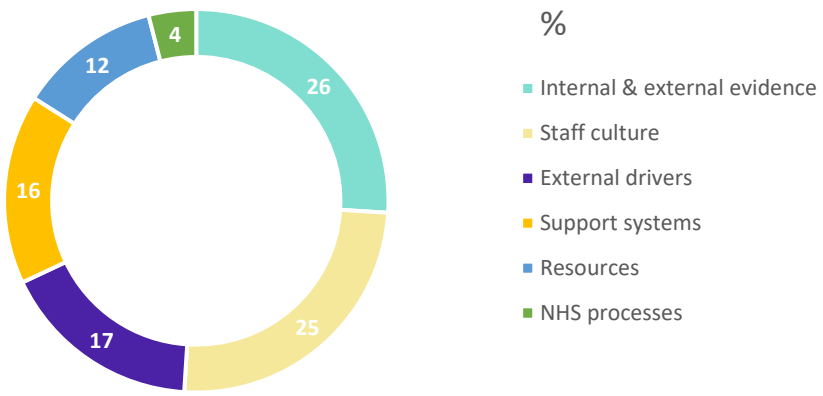
Pre and post training respondents were asked to identify **barriers** to undertaking QI. The majority of responses (31%) were words related to the theme around time available for staff to undertake QI (Figure 1). Words or terms used were grouped into eight final categories according to 26 initial thematic codes.

Figure 1: *Frequency of themes associated with barriers as described by respondents (%)*



When we asked respondents to identify **enablers** to undertaking QI. Most responses (26%) were words related to a theme for internal and external evidence which were perceived to drive or inform QI (see Figure 2). Words or terms used were grouped into six categories according to 34 initial thematic codes.

Figure 2: *Frequency of themes associated with enablers as described by respondents (%)*



From theory to practice: creating action

The training enabled respondents to initiate 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 anti-racist 'knowledge agents' or allies.

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. 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.

Discussion

Box 1: The King's Fund

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 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 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 current national context 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. The evaluation of the Black Maternity Matters programme has yielded important insights for its continued development and 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 perinatal staff are becoming increasingly aware of the health disparities faced by Black women and other racially minoritised groups, and the recent high-profile reports, such as MBRRACE, which have emphasised the increasing gaps in health inequalities for this group of women and birthers.

Pre and post training data has demonstrated that the 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. Our evaluation evidenced that respondents had overestimated their understanding of their cultural competency at the start of the programme (in 28 out of 31 domains). This links with the broader literature which suggests that individuals tend to underestimate their own levels of bias.

This presence 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. To be able to demonstrate this effect 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 impacts 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?

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 having managers in the same space as delivery workforce had the potential to change the dynamic of learning and the safe space of sharing, and highlights a common tension between workforce and management to be taken into consideration when planning training approaches across the workforce, and consider the need to develop specific managerial training for operational team leaders.

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?

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 shows an increase between baseline and end of training across all 10 domain areas. Future work may wish to explore the domains showing the lowest differences in anti-racist practice at work and consider how these can be reflected in a behaviour change approach that continue to enhance psychological safety back within clinical settings once training is completed.

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 suggests that three distinct areas of competency are commonly associated with and expected from effective anti-racism and diversity trainers (external knowledge, internal knowledge/understanding and facilitation skills). 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.

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

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. 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.

Whilst the multi-disciplinary perinatal team approach facilitated networking and enhanced learning, for some staff undertaking a QI project felt isolating if they were the only ones representing their team or service or worked night shifts. There remain 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 at understanding and providing better care.

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

We found 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 an increase in staff reporting that they would intervene if they saw racist or discriminatory behaviour; increased if we take in to account the Dunning-Kruger effect.

We also see an increase in staff reporting being actively involved in anti-racist initiatives.

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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