Health Innovation West of England

# Black Maternity Matters Senior Leadership Cohorts 1 and 2 Training Evaluation Report

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# Executive Summary

## Background

The Black Maternity Matters (BMM) Senior Leadership (SLT) programme is a 6-month bespoke anti-racist training programme providing an immersion in an expert led training experience integrating critical race theory, whiteness theory, and critical pedagogy. The programme works on the premise that the role of the senior leader is essential in driving anti-racist Practice and transformation, including the conversion of this into improvements in trust or organisational culture. This paper reports on the results of two BMM SLT training courses held between March and August 2024.

## Evaluation Methods

This evaluation took a questionnaire based, mixed-methods approach. Participants from each cohort completed a comprehensive questionnaire after the training covering cultural competency, leadership environment, skills and behavioural change; and free-text questions on experiences and impacts. The evaluation questions were:

1. Did the training make a difference to the **cultural competency** of the participants?
2. Are participants in a position to put their **training into practice**?
3. What were the **overall impacts** of the training on the participants?

## Cultural Competency

The largest changes were in cultural awareness, with sizable increases in people's awareness of their own privilege and ability to challenge their own stereotypes. The next largest were in cultural knowledge and skills respectively, with participants on average showing some change in all skills areas, but not as large as in knowledge and awareness.

| Average increases in each cultural competency question item | Sizable change | Some Change | No Change |
|---|---|---|---|
| **Awareness:** 10 items on self- awareness of cultural background, biases, and how they affect interactions with others. | 7 | 3 | 0 |
| **Knowledge:** 10 items on knowledge of other cultures' worldviews, practices, and experiences. | 4 | 5 | 1 |
| **Skills:** 11 items on ability to communicate and adapt to different cultures, recognise own biases and to take action to challenge racism. | 0 | 11 | 0 |

## Putting training into practice

We assessed the extent to which participants had the right skills and environment to put their training into practice.

**Leadership skills & environment**: Most participants agreed that following the training they had **some** of the necessary leadership skills to address racism. They mostly agreed that they had the skills to address and prioritise racism and act to tackle health inequalities. They were more neutral on their ability to grow inclusive leaders. They were also neutral on whether their organisational leadership environment was conducive to anti-racist activities, with most agreeing that white culture is the norm in the organisation.

**Psychological safety** is an important pre-requisite for making organisational changes, and therefore necessary for leaders to make anti-racist changes. Most participants broadly agreed they felt psychologically safe in their organisation. There were some outliers, with a few participants feeling that their organisation did not provide clear expectations, and they were not free to makes mistakes or ask for help.

**Behaviour change**: Participants mostly felt they had the capability, opportunity and motivation to make changes as senior leaders. Participants were left highly motivated to implement changes because of the training, but making anti-racist changes is still not automatic for of them and will require thought and effort on their part.

## Overall impacts

Participants rated the training as highly useful, with 90% of participants noticing a change in the way that they lead since participating in the programme. Participants had embarked on a wide range of anti-racist actions and initiatives, including championing and advocacy, changing policy and practice, promoting anti-racist training, developing anti-racist materials and images, and improving data collection and M&E.

## Recommendations

**SLT BMM training is valuable and should be continued;** Participants found the training transformational, and demonstrated large shifts in knowledge and skill acquisition. 98% of participants attended all three course days.

**There is a continued need for ongoing support:** Participants recognised that anti-racist practice is a lifetime learning journey and acknowledged that changing their behaviour to implement anti-racist leadership at work was not automatic.

**The QI / transformation support needs to be communicated more clearly.** Participants have been carrying out a range of anti-racist transformation work but had not always sought QI support for this. Anti Racist QI is a new concept and there is a need to increase confidence in using the IHI Model and associated methodologies.

**The course promotion needs to be reviewed** in the context of a change in culture, including a shift towards dismantling EDI initiatives.

**Book summaries should be provided** to enable participants to get an overview of a book and enable them to attend a book club even if they have not finished the book.

**Take action to ensure high levels of questionnaire completion**; for example, making questionnaires anonymous and creating space to complete them on the final day.

**Future evaluations should include system-level and clinical impacts.** These evaluations should be planned and sequenced so that they are underpinned by a clear programme theory and hypothesis before impacts are measured.

## Acknowledgements and Contact Details

Health Innovation West of England would like to acknowledge and thank the following people for all their contributions to the evaluation report: Ann Remmers, Nathalie Delaney and Jelena Ivanovich from the Black Maternity Matters Project Group, members of the Black Maternity Matters Steering Group (Aisha Thomas, Katie Donovan-Adekanmbi, Sonah Paton, Tarnia Mason) and the Senior Leaders who attended the training and took part in the evaluation.

## Contact details

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# 1. Introduction

## 1.1 Background

The 2021 MBRRACE-UK report highlighted Black, mixed-race and Asian women are at a greater risk of maternal mortality. Following this, in 2021, the Black Maternity Matters (BMM) Collaboration was launched as a partnership between Health Innovation West of England, Black Mothers Matter, Representation Matters and BCohCo. The aim of the collaboration is to deliver targeted anti-racism education, peer support, support community and encourage quality improvement (QI) transformation projects for perinatal staff within the West of England. Four cohorts of perinatal training were delivered between May 2022 and March 2025.

## 1.2 Black Maternity Matters Senior Leadership (SLT) Training

Senior level advocacy and support for anti-racist practice has been identified as an essential enabler for change within NHS systems. The introduction of the senior leadership team (SLT) Cohorts aims to facilitate a positive impact of engaged senior leadership undertaking the programme alongside senior level sponsorship. The need for senior level advocacy was also identified by participants in the previous four perinatal BMM cohorts. Participants felt it would be valuable for their leadership to also receive anti-racist training so they could support their quality improvement projects.

The SLT programme is a 6-month bespoke anti-racist training programme providing an immersion in an expert led training experience integrating critical race theory, whiteness theory, and critical pedagogy. The programme works on the premise that the role of the senior leader is essential in driving anti-racist practice and transformation, including the conversion of this into improvements in trust or organisational culture. Participation in this cohort aims to equip NHS leaders with the knowledge and tools needed to champion equitable care within the healthcare system via the lens of race.

## 1.3 Training Content

A specialised programme was created targeted at senior leaders, including senior executives, chairs, non-executive chairs, consultants, directors and other senior workforce members. The BMM SLT programme supports individuals to understand the individual and society in perpetuating racial inequity and explores the systemic changes required to eliminate racial disparities in health and social care, the development of supportive policies, and strategies for embedding equitable care practices throughout the NHS and wider systems. It aims to empower leaders to drive transformative change within their respective departments.

The SLT cohort training included:

- Three face-to-face training days, covering:
    - Understanding the Landscape and Building a Foundation
    - Strategies for Change and Quality Improvement
    - Action Planning and Implementation

- Three book clubs covering:
    - My Black Motherhood by Sandra Igwe
    - Divided: Racism, Medicine and Why We Need to Decolonise Healthcare by Dr Annabel Sowemimo
    - The Anti-Racist Organization: Dismantling Systemic Racism in the Workplace by Dr Shereen Daniels
- An individual anti-racist strategic transformation project for leaders to implement in their organisations.

The BMM model is built on the foundations that this is a learning journey and not a single period of knowledge acquisition. BMM facilitates a continued community of practice through online learning events, action learning sets, and one to one coaching and group sessions to move learning into action at a strategic level, utilising the Hogan Model.

Participants are encouraged to engage in the BMM Collaborative and if relevant, the Quality Improvement Series of virtual workshops and receive coaching to enable development and implementation of a transformation project. In addition, senior leaders are offered access to the *Becoming an Anti-Racist Leader* coaching component, led by Dr Lateesha Osborne, using the Hogan Method. This element supports individuals in one-to-one and group sessions to align their thinking, personality type and leadership roles to take action at a strategic level.

## 1.4 Document Purpose

This report presents an evaluation of the first two senior leadership cohorts by providing both quantitative and qualitative analysis of the questionnaire responses.

This report addresses the following evaluation questions:

1. Did the training make a difference to the cultural competency of the participants?
2. Are participants in a position to put their training into practice? i.e.
    - Do they have the leadership skills necessary to make changes?
    - Do they feel psychologically safe to use their skills?
    - Do they have opportunity, motivation and capability to change anti-racist behaviour?
3. What were the overall impacts of the training?

# 2. Methods

## 2.1 Overall Approach

The participants were asked to complete a questionnaire pre-training and post-training on their competency environment and training impacts. This questionnaire was sent via email. For cohort 1, participants received the post-training questionnaire on the final day of training, and an evaluator was present who encouraged completion. For cohort 2, the post-training questionnaire was sent immediately after the training and an evaluator from HIWE attended the final session to invite participants to take part in online evaluation interviews.

The post-training questionnaire also included questions that asked the participants to rate their pre-training competency again retrospectively. The topics covered in the questionnaire were cultural competency, psychological safety, leadership skills, behaviour change and experiences of the training course. To maintain integrity, validated questions were used to look at most of these topics. (see table 1)

In the evaluation of the perinatal training[1] we found evidence of the Dunning-Kruger effect. This is where a person overestimates their own competence in a topic area prior to being trained in it, and when asked retrospectively, they rate their pre-training competence as lower than they did before. We therefore decided to use the retrospective pre-test of competency as a baseline for the senior leaders' cultural competency levels in this evaluation.

## 2.2 Analysis methods

We used descriptive statistics for the quantitative questionnaire answers (1 to 4.1 in the table 1 below), and qualitative thematic analysis for the two qualitative questions (4.2 in the table 1 below).

## 2.3 Contributions

Petra Downing (PD), Ellie Quinlan (EQ) and Mairead Murphy (MM) are members of the independent Evaluation and Insights Team at Health Innovation West of England (HIWE). Noshin Emamiannaeini - Menzies (NEM) is part of the programme team at HIWE who co-designed and supports the implementation of the anti-racist training. Both PD and MM have attended BMM training in different cohorts. For purposes of positionality, NEM is racialised as Brown, and PD is also racialised as Brown.

PD delivered the quantitative analysis, supported by MM. PD and EQ carried out the qualitative analysis supervised by MM. MM designed the report structure and oversaw the delivery of the report. NM supported with describing the background to the BMM training, and with interpreting the findings in the discussion and developing recommendations based on the analysis. MM checked the recommendations to ensure that they were grounded in the data and signed off the final evaluation report.

## 2.4 Language used in this evaluation

BMM is anti-racist training. Anti-racism means **active and deliberate actions** to oppose, challenge, and dismantle racism in all forms: individual, institutional, and structural. Some of the questionnaires we adopted used the phrase "cultural competency". This refers to the ability to **interact effectively and respectfully with people from different cultures**.

We did not adjust the wording from "cultural competency" to "anti-racism" because these are validated instruments (see Table 1), which have been tested as valid and reliable. Adjusting the wording would invalidate the robust testing these instruments have undergone. Nonetheless the constructs measured by the cultural competency questionnaires contain multiple aspects of anti-racism, and this is evidenced in the questionnaire analysis and discussion to this evaluation.

[1] Evaluation shows Black Maternity Matters is increasing the knowledge, skills and confidence of maternity and neonatal staff - Health Innovation West of England

## 2.5 Areas covered by the questionnaire

The table below lists the different constructs covered by the questionnaire completed by the course participants and cites the validated questionnaires which were used.

*Table 1 List of sub-sections in the questionnaire sent to BMM training participants*

| | | | | | | |
|---|---|---|---|---|---|---|
| Section 3.1: Demographics of attendees | | | | | | |
| Section 3.2: Shifts in cultural competency from before and after the training, assessed retrospectively at training completion | | | | | | |
| 3.2 | 3.2.1 | Cultural competency - awareness | Awareness, knowledge and skills in own biases and also engaging with diverse cultures in their organisation | *10 questions* | Retrospective pre-test /post-test | Adapted from Cultural Competence Self-assessment Checklist. Central Vancouver Island Multicultural Society. (2012, September 19). |
| | 3.2.2 | Cultural competency - knowledge | | *10 questions* | Retrospective pre-test /post-test | |
| | 3.2.3 | Cultural competency - skills | | *11 questions* | Retrospective pre-test /post-test | |
| Section 3: Assessment of how the leaders environment, skills and context at the end of the training will support implementation of the training or otherwise | | | | | | |
| 3.3 | 3.3.1 | Leadership | Sense of safety within the leadership group the participants work with | *11 questions* | Post-test | Internal non-validated measure |
| | 3.3.2 | Psychological Safety | Feeling they a safe environment as a leader and creating one in the wider team | *10 questions* | Post-test | Adapted from: 04. PSAP. Measuring Psychological Safety. |
| | 3.3.3 | Behavioural Change | Confidence in applying anti-racist leadership at work (COM-B) | *6 questions* | Post-test | Adapted from Keyworth et al (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 |
| Section 4: Individual assessments of the training value and self-assessed impacts of the training | | | | | | |
| 3.4 | 3.4.1<br>3.4.2 | Experience of the programme & learning outcomes | Value of different aspects of the training | *6 questions* | Post-test | Internal non-validated measure |
| | 4.2.3<br>4.2.4 | Qualitative questions | in relation to this training:<br>a) Feedback about actions taken | *2 questions* | Post-test | Internal non-validated measure |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | b) Feedback about changes in leadership at team , individual or system level | | | |

# 3. Results

This section describes the results of the responses of the post-training survey.

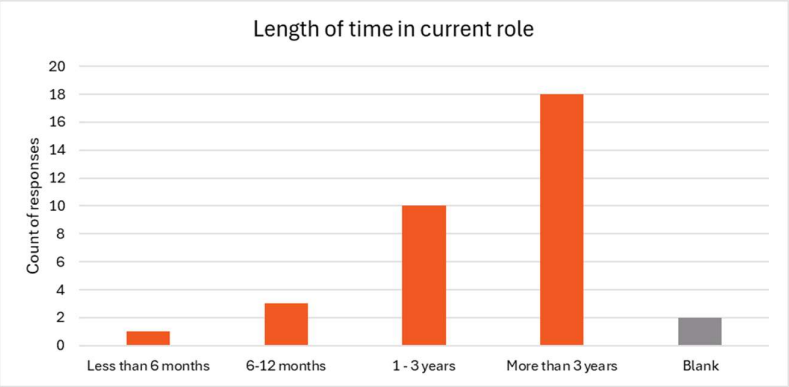
## 3.1 SLT training attendees

There were 49 attendees across both leadership training cohorts and a total of 34 responses, n=21 responses from the first cohort and n=13 responses from the second cohort (table 2). Not every survey participant answered every question. At the time of completing this questionnaire, most participants (88%) had been in their current leadership role for more than one year (Figure 1). There was a very high rate of course completion (98%).

*Table 2 Number of participants in the training who gave feedback in the questionnaire*

| Cohort name | Commenced training (n) | Completed training (n) | Completed questionnaire (n) | Completed questionnaire (%) |
|---|---|---|---|---|
| SLT Cohort 1 | 25 | 25 | 21 | 84% |
| SLT Cohort 2 | 25 | 24 | 13 | 54% |
| **Total** | **50** | **49** | **34** | **69%** |

Figure 1 Length of time in current role of respondents in the questionnaire




## 3.2 Cultural competency

This section addresses the evaluation question: Did the training make a difference to the cultural competency of the senior leaders who attended?

There were 31 statements that assessed trainee's cultural competency levels. These questions looked at a participant's ability to understand and interact with colleagues and patients from diverse backgrounds. The post- questionnaire asked the participants to re-rate their cultural competency retrospectively at the start of their training and then rate their cultural competency after the training. These are the areas covered in the questionnaire:

- awareness - a person is aware of the biases they hold based on their own culture.
- knowledge – a person understands differences in norms and values of other cultures.
- skills –a person is able to adapt their behaviour and communication to another person's culture and be respectful of others.

Participants were asked to self-rate on a set of traits and behaviours which, if demonstrated, would indicate that they had high levels of cultural competency. The ratings were scored from never (scored 1) to always (scored 4).

We calculated the average before and after scores and charted these. In addition, we used the following rule of thumb to indicate the size of the difference:

*Table 3 Guide of change in difference in the cultural competency questions*.

| **Change in difference** | **Visual** |
|---|---|
| One point change or more: Sizable change | ⇧⇧ |
| 0.5 to one point change: Some change | ⇧ |
| Less than 0.5 change: No change | ⇔ |

### 3.2.1 Awareness

Figure 2 shows self-assessed changes in **cultural competency awareness**. The average scores increased across all questions. For seven out of 10 answers the change was sizable (more than a 1-point change) and for the other three there was some change (between 0.5- and 1-point change). The largest change was seen in people's awareness of their own privilege. The next largest were in people's ability to challenge their own stereotypes, reflect on how culture informs their judgment and accept ambiguity.

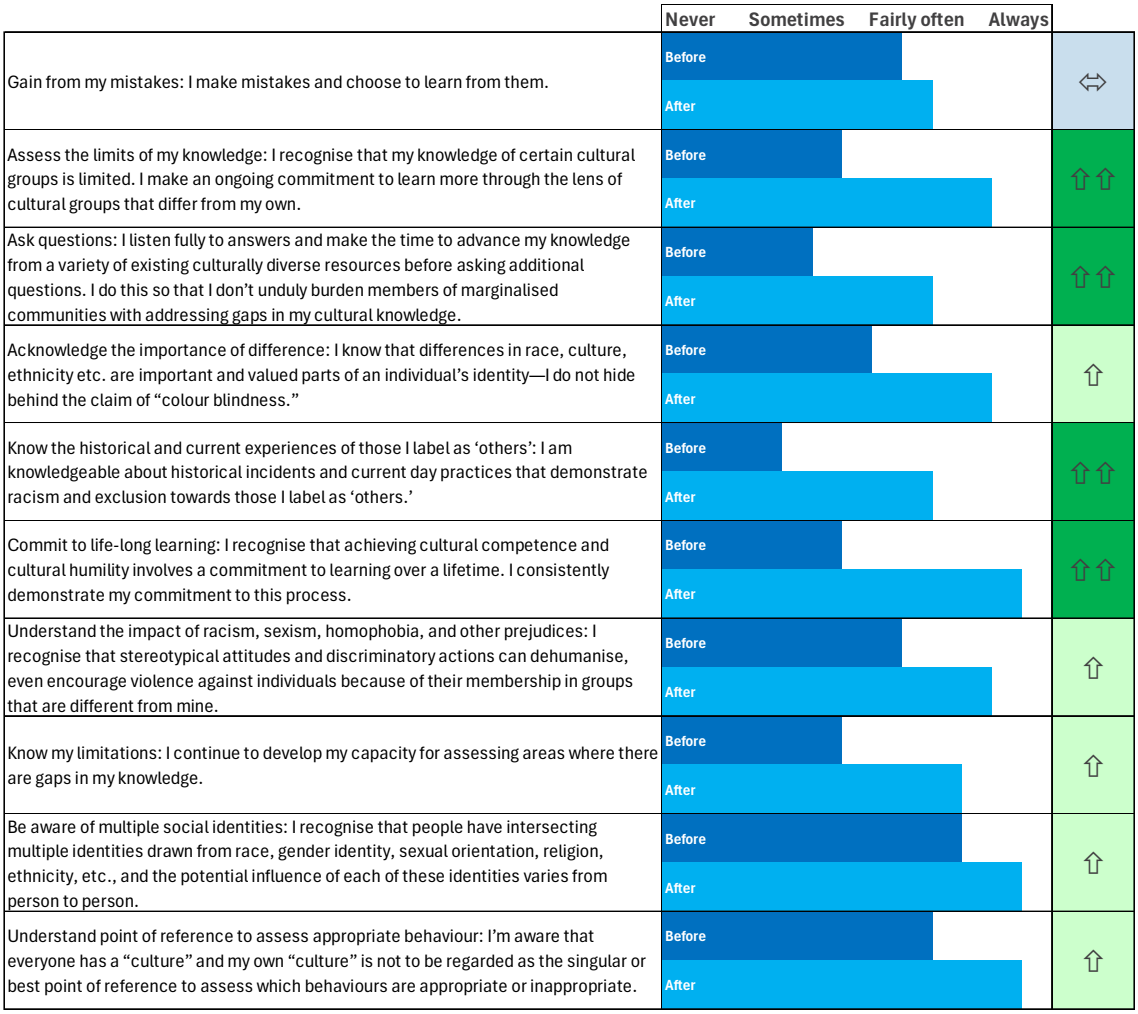
*Figure 2 Self-assessed pre-post changes in cultural competency awareness*

### 3.2.2 Knowledge

Figure 3 shows self-assessed changes in **cultural competency knowledge**. The changes in knowledge were less marked than the changes in cultural competency awareness, but average scores still increased across all but one of the questions (the average participant perceived little or no change in their ability to learn from mistakes since participating in the programme). For the remaining questions, four had a marked change (more than 1-point) and five had some change.

The greatest change was in participants' recognition that achieving cultural competency involves a commitment to lifelong learning. Participants also substantially increased their knowledge of the historical incidents and current day practices that demonstrate racism and exclusion; this question had the lowest baseline score.

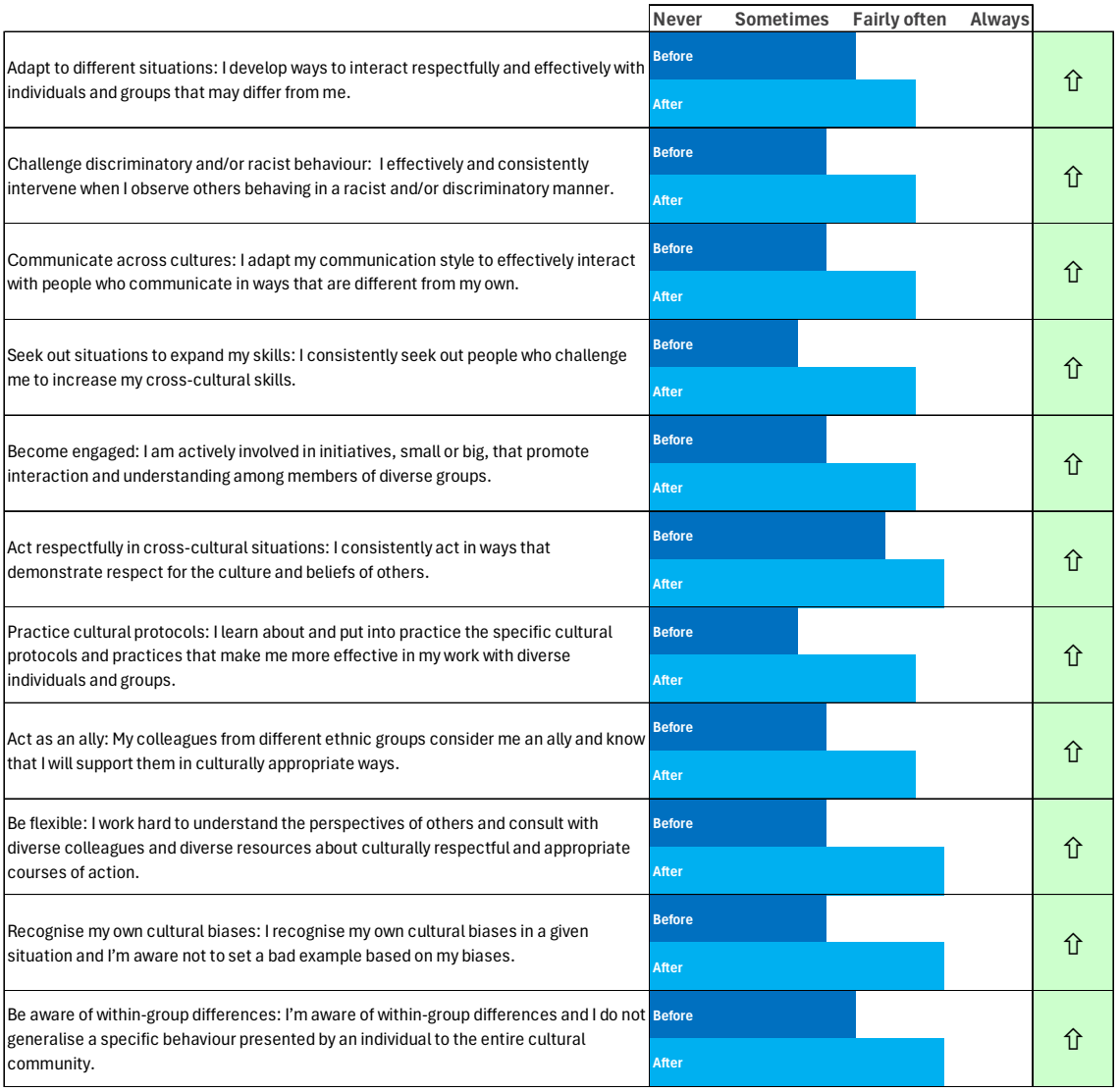
*Figure 3 Self-assessed pre-post changes in cultural competency knowledge*



### 3.2.3 Skills

Figure 4 shows self-assessed changes in **cultural competency skills**. The changes in skills were less marked than both in cultural competency awareness and knowledge. The changes were very consistent across all the questions; average scores for every question improved on average between 0.5 and 1 point. The lowest baseline scores were in actively seeking out situations to expand cross-cultural skills and in learning about and putting into practice specific cultural protocols.

*Figure 4: Self-assessed pre-post changes in cultural competency skills*



## 3.3 Putting training into practice

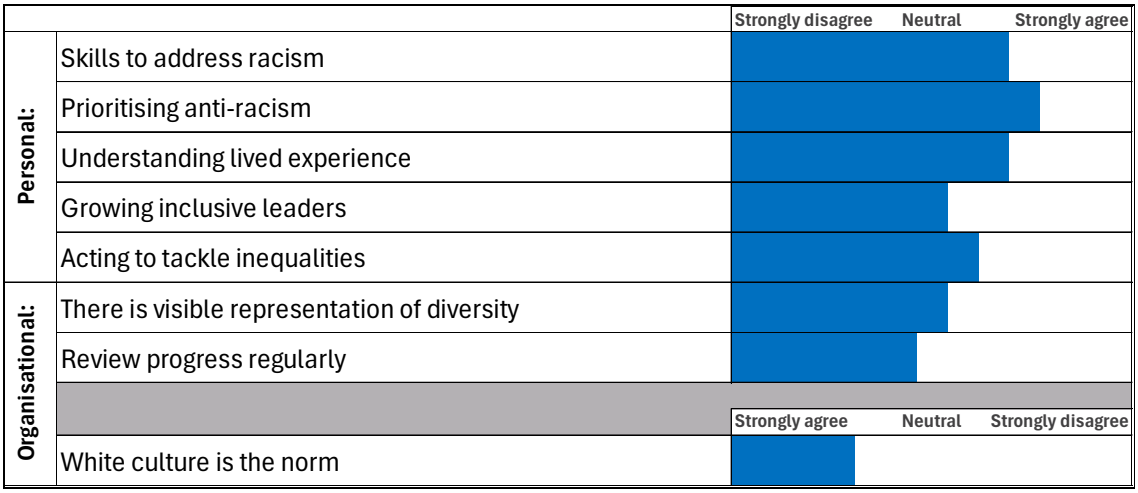
This section addresses the evaluation question: Are participants in a position to put their training into practice? i.e.

- Do they have the **leadership skills** necessary to make changes?
- Do they feel **psychologically safe** to use their skills?
- Do they have the opportunity, motivation and the capability to **change behaviour**?

### 3.3.1 Leadership Skills

To assess leadership skills, participants were given a series of statements about both their personal leadership skills, and about the leadership skills inherent in their organisation and asked to endorse these (strongly agree to strongly disagree). The average scores after the training are shown in Figure 5.

*Figure 5 Self-assessed responses to individual and organisational anti-racist leadership skills*




| | Key: |
|---|---|
| Personal | **1.** Skills to address racism: I have the skillset to appropriately address racism within the workplace and the teams I manage. |
| | **2.** Prioritising anti-racism: during the last month I have spent time on anti-racist work in my organisation. |
| | **3.** Understanding lived experience: during the last month I have ensured the voices and experiences of racially minoritised women are heard, and have supported others to share their lived experience. |
| | **4.** Growing inclusive leaders: I create the opportunities for racially minoritised colleagues to grow and be included, and to expand the diversity of leaders in my organisation. |
| | **5.** Acting to tackle inequalities: during the last month I have taken actions to address racial inequalities and measure the impact these actions have made. |
| Organisational | **6.** There is visible representation of diversity throughout my workplace that conveys our commitment to racial justice from our Equality, Diversity and Inclusion (EDI) statements and policies. This could be through arts, messaging or design. |
| | **7.** Review progress regularly: my organisation has built anti-racism into its EDI targets and measures their progress. |
| | **8.** White culture is the norm in my organisation and those who are racially minoritised are expected to assimilate into our existing organisational culture. |

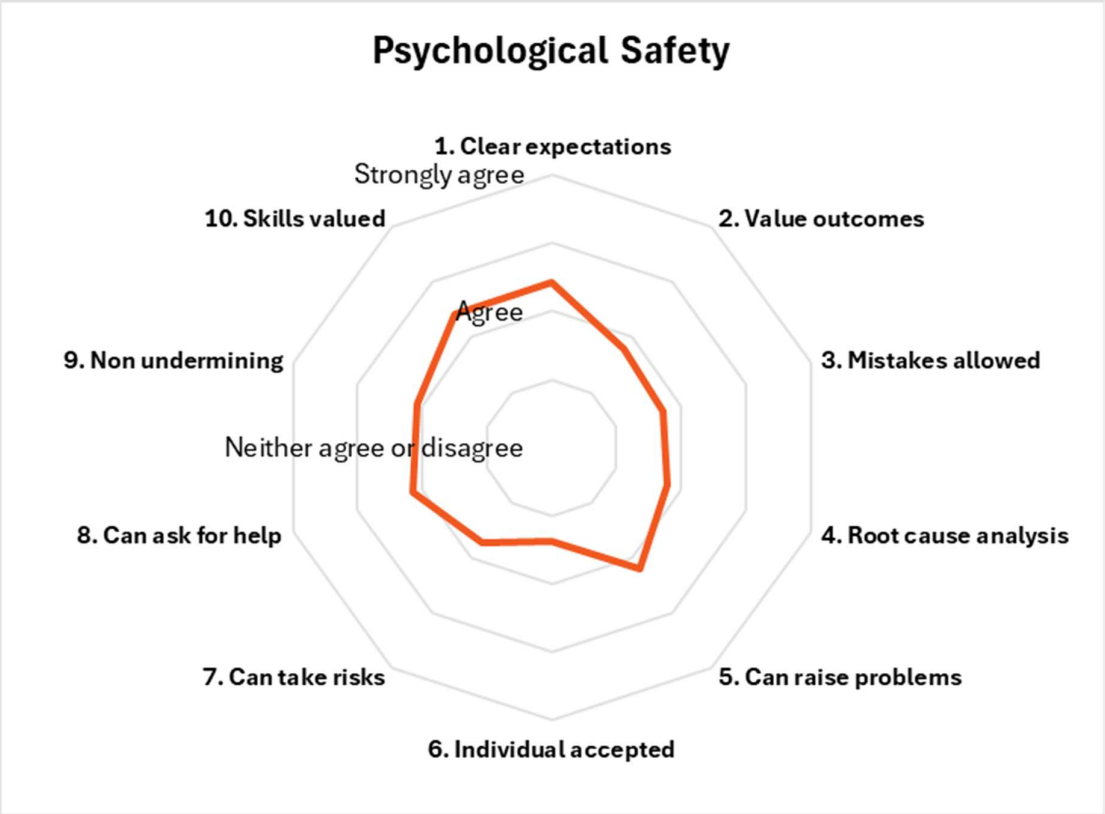
In terms of personal leadership skills and action, the results showed that most participants strongly agreed that they had prioritised anti-racism, spending some time on anti-racist work in the last month. Participants mostly agreed that they now had the skills to address racism within their team and had supported racially minoritised women to share their lived experience within the last month. Participants were more neutral about whether they had actively created opportunities to expand the diversity of leaders within their workplace.

Participants scored the organisational anti-racist leadership environment less highly than their own personal anti-racist leadership skills. Most participants agreed that white culture is the norm in their organisation and racially minoritised people are expected to assimilate into this culture. They were neutral (neither agreed or disagreed) about whether their organisation measures their progress against anti-racism and creates visible representation of diversity through the workplace through arts, messaging or design.

### 3.3.2 Psychological Safety

Psychological safety is how safe a person feels that they are allowed to make mistakes, raise issues and ask for help. To assess whether participants felt **psychologically safe** to use their skills in the context of their leadership team, they were given a series of statements about psychological safety and asked to endorse these (strongly agree to strongly disagree). The average scores after the training are shown in a spider diagram in Figure 6 and a box plot in Figure 7.

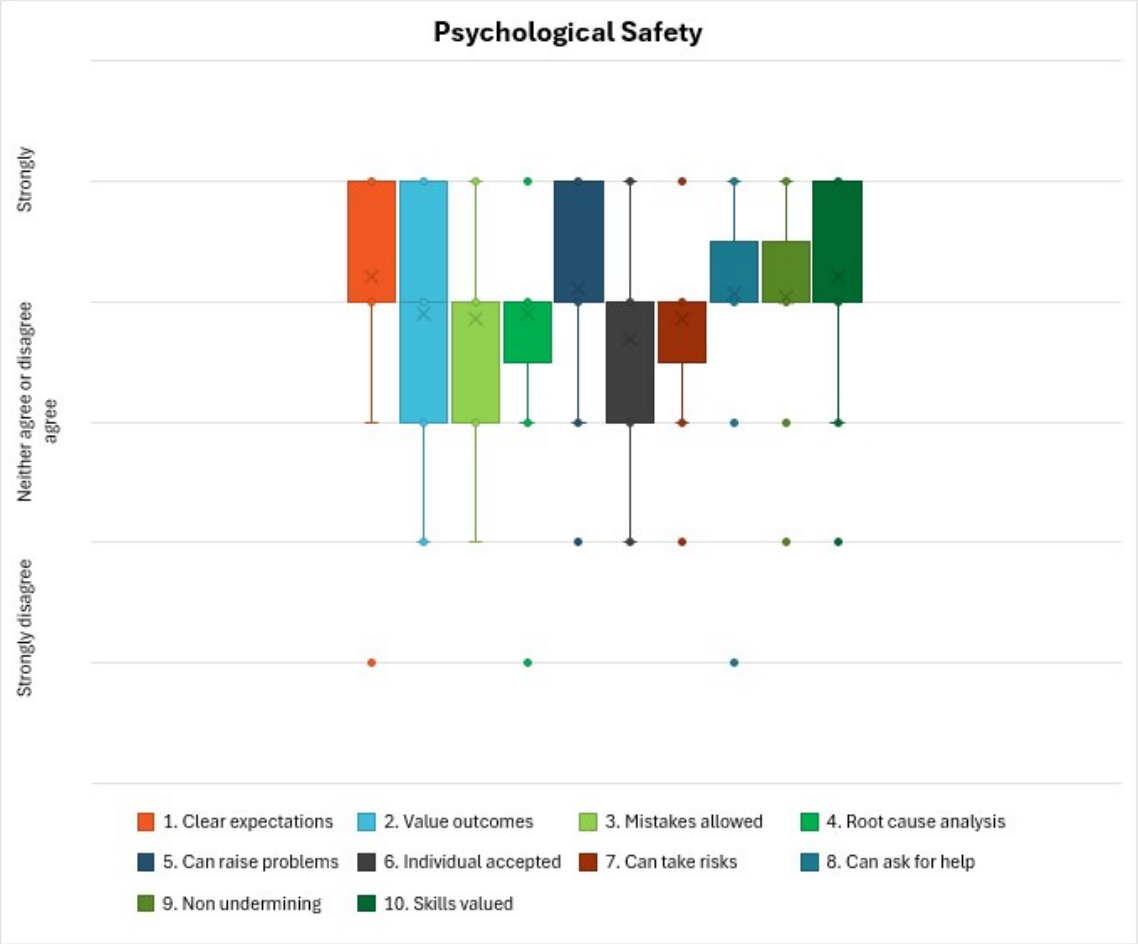
*Figure 6 Spider diagram of self-assessed responses to psychological safety*




**Key to the labels:**

| | |
|---|---|
| 1. Clear expectations | Within my leadership team, I understand what is expected of me. |
| 2. Value outcomes | We value outcomes more than outputs or inputs, and nobody needs to "look busy". |
| 3. Mistakes allowed | If I make a mistake on my leadership team, it is never held against me. |
| 4. Root cause analysis | When something goes wrong, we work as a leadership team to find the systemic cause. |
| 5. Can raise problems | All members of my leadership team feel able to bring up problems and tough issues. |
| 6. Individual accepted | Members of my leadership team never reject others for being different and nobody is left out. |
| 7. Can take risks | It is safe for me to take a risk on my leadership team. |
| 8. Can ask for help | It is easy for me to ask other members of my leadership team for help. |
| 9.Non undermining | Nobody on my leadership team would deliberately act in a way that undermines my efforts. |
| 10. Skills valued | My unique skills and talents are valued and utilised in my work as part of my leadership team. |

*Figure 7 Boxplot diagram of self-assessed responses to psychological safety*




The spider diagram shows that most of the median scores are around the central level of "agree". The two highest scores were clear expectations (within my leadership team, I understand what is expected of me) and skills valued (my unique skills and talents are valued and utilised in my work as part of my leadership team). The lowest score was individuals accepted (members of my leadership team never reject others for being different and nobody is left out). The boxplot shows some outliers, with three participants responded they strongly disagreed with the statements that their organisation provides clear expectations, they were allowed mistakes or could ask for help.

### 3.3.3 Behaviour Change

To assess whether participants felt they had the opportunity, motivation and the capability to change behaviour we used a validated questionnaire based on the COM-B model of behavioural change. The COM-B framework looks at whether the participants feel they have the three components to make a behavioural change; they must feel they are capable (C), have the opportunity (O) and the motivation (M). This theoretical framework is illustrated in Figure 7.

*Figure 7 Diagram of COM-B method of behavioural change*[2]


The results from the questions on behaviour change are shown in Figure 8.

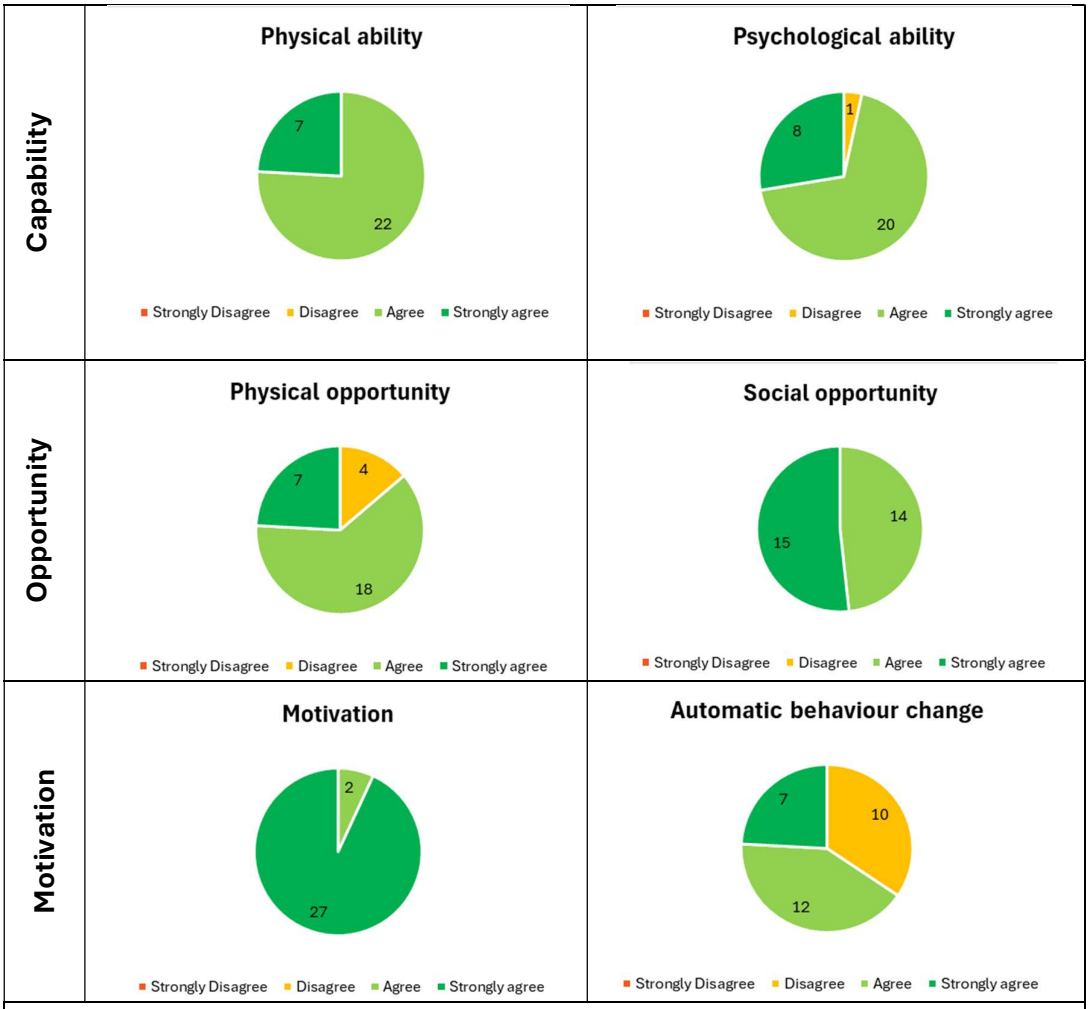
**Capability**: Participants broadly agreed that they had both the physical and the psychological capability to make changes at work. Most responses to these questions were "agree" with about a quarter for each rated as "strongly agree". Only one participant disagreed, feeling that they did not have the psychological capability to implement anti-racist leadership at work (i.e. the right knowledge, interpersonal skills and cognition).

**Opportunity**: Participants strongly endorsed that they had the social opportunity to make behavioural changes at their workplace (good relationships with colleagues, support from manager) with more than 50% strongly agreeing with this and the remainder agreeing. Many participants were also positive about the physical opportunity to make changes (e.g. the necessary time or resources), but some were less sure about this: only 24% (n=7/29) strongly agreed and 14% (n=4/19) disagreed.

**Motivation**: All respondents agreed they were motivated to make changes with 93% (n=27/29) strongly agreeing with this. Respondents did not find this behaviour change to be automatic: 33% (n=10/29) disagreed that they could make changes to their behaviour automatically without much thought and only 24% (n=7/29) strongly agreed.

[2] COM-B model: a framework for understanding behavior | Download Scientific Diagram

*Figure 8 Self-assessed responses to behavioural change questions*




KEY: List of questions that were in the survey corresponding to each chart:

1. **Physically Able**: I am PHYSICALLY able to implement anti-racist leadership at work (e.g. you have the physical stamina, strength or skill).
2. **Psychologically Able:** I am PSYCHOLOGICALLY able to implement anti-racist leadership at work (e.g. you have the right knowledge, interpersonal skills and cognition).
3. **Physical Opportunity:** I have the PHYSICAL opportunity to implement anti-racist leadership at work (e.g. the necessary time or resources).
4. **Social Opportunity**: I have the SOCIAL opportunity to implement anti-racist leadership at work (e.g. good relationships with colleagues, support from manager).
5. **Motivation**: I am motivated to implement anti-racist leadership at work (e.g. you desire or see the need to do this).
6. **Automatic Behaviour Change**: Changing my behaviour to implement anti-racist leadership at work is something that I do automatically (e.g. it happens without much thought).

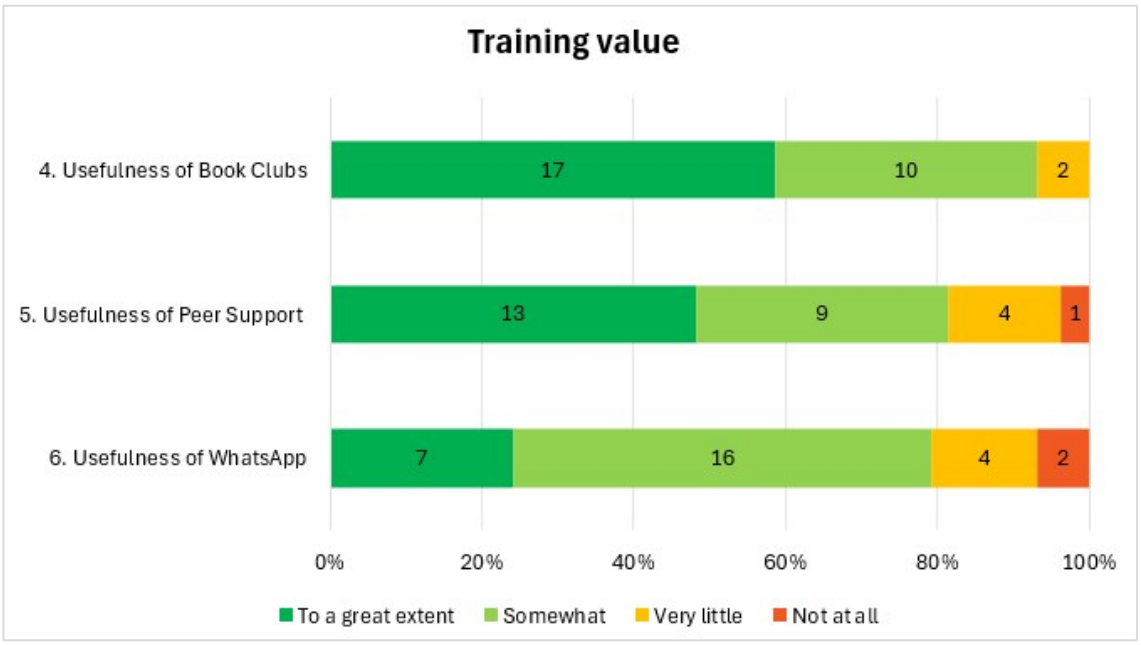
## 3.4 Overall training impacts

This section addresses the evaluation question: What were the overall impacts of the training? This was assessed through both quantitative and qualitative analysis; participates rated the usefulness (3.4.1) and impact (3.4.3) of the training. They also gave qualitative information on the anti-racist actions they had taken since completing the training (3.4.2) and the changes they had noticed in their leadership style since completing the training (3.4.4)

### 3.4.1 Usefulness of the training

The participants were asked to rate the usefulness of the training. Nearly all (93%) of the participants found the book clubs useful, 81% of the participants saw the usefulness of peer support and 79% of participants saw the usefulness of WhatsApp support.

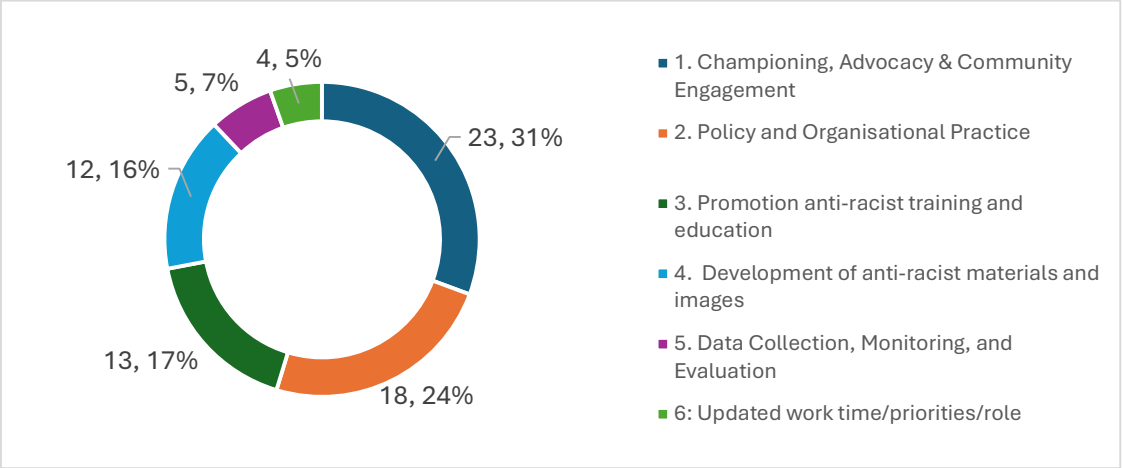
*Figure 9 Self-assessed responses of the usefulness of different aspects of the training*




### 3.4.2 Actions taken since the training

The participants were asked to give more information about the sort of activities they had considered or started following this training. We carried out a thematic analysis of responses. There were n=21 themes from participants in SLT cohort 1 and 2.

*Figure 10 Pie chart of thematic analysis showing the participant actions*




1. Championing, advocacy & community engagement

The majority of themes from the responses (n=23) expressed they had taken action by becoming advocates and changing their behaviour. One response cited from this training they had a change in their thought process and behaviour change to actively challenging and they were, 'challenging unconscious bias, comments, and behaviour constantly' and another participant commented they were making active changes about how they view situations by 'applying anti-racist lens when assessing data implementing change.' One participant felt they wanted to be a safe space ensuring marginalised voices felt heard, 'I plan to advertise myself as a go to person that our racially minoritised students can come to with issues.'

Five participants focus their advocacy on engaging their community with one participant commenting they were, 'thinking more widely about community engagement to underpin wider delivery.'

2. Change in policy and organisational practice

Feedback from 18 responses from the participants showed this training supported them to commit to an action looking at a change in policy or practices within their organisation.

Six participants expressed they or their organisations are reviewing or updating policies within their organisations with one participant noting there are changes in, 'Development of a Perinatal Anti Racist Framework.'

Despite a participant expressing they personally wanted to see changes in their organisation, they acknowledged the time barriers to implementing these, 'although ED&I is highlighted as [a] key area of improvement for my work area - there is very limited time to follow up on initial discussions or even from the team away day.'

3. Promoting anti-racist training and education

Thirteen participants had started or considered starting anti-racist training within their organisations.

Within the theme of anti-racist training, there were three subthemes identified. Three participants have focussed on senior leadership with one participant responding that they, 'introduced our Board to anti-racism training.' Two participants focussed their promotion at university-level teaching with, 'anti-racism training for midwifery lecturers.' Two participants focussed their efforts at single events, 'delivery of Standing Together Against Racism' and 'delivering a Ramadan Awareness session.'

4. Development and sharing of anti-racist materials and images

Twelve participants reported they were working towards producing material that can be used to promote and spread anti-racism. Four participants made specific reference to language used by their organisation. One participant noted they were, 'working with staff networks on guidance for use of languages in the workplace to ensure inclusivity, belonging and safety.' Another participant felt they wanted to remove physical reminders of racist language in their organisation, and they had, 'started [the] process to rename medical equipment where eponymous names have been given that honour slave-owners and reinforce historical inequalities.'

One participant expressed they were taking a creative approach to their actions by planning a, 'photography project' and taking an active role in visually promoting anti-racism and wanted to, 'increase the diversity of images we use (within clinics/units, parents leaflets/posters, online presence).'

5. Data Collection, monitoring and feedback

Five participants gave feedback that they have looked at how their organisation collects or analyses data with a focus on ethnic minorities. One participant commented they were making sure when talking with parents, they were patient-focussed and gave parents an opportunity to expand and fully capture their experiences and they, 'ensure all regional parent feedback forms ask specifically if parents feel their ethnicity or race impacted their experience and an opportunity to explain.'

One participant was aware that, 'students are experiencing what appears to be overt racism' and there was a gap in reporting, so they were implementing a system to capture, 'checks and balance'.

6. Updated work time/priorities/role

Four participants gave feedback that after the training their action was to create space in their work time so they could focus on taking actions focussed on anti-racism.

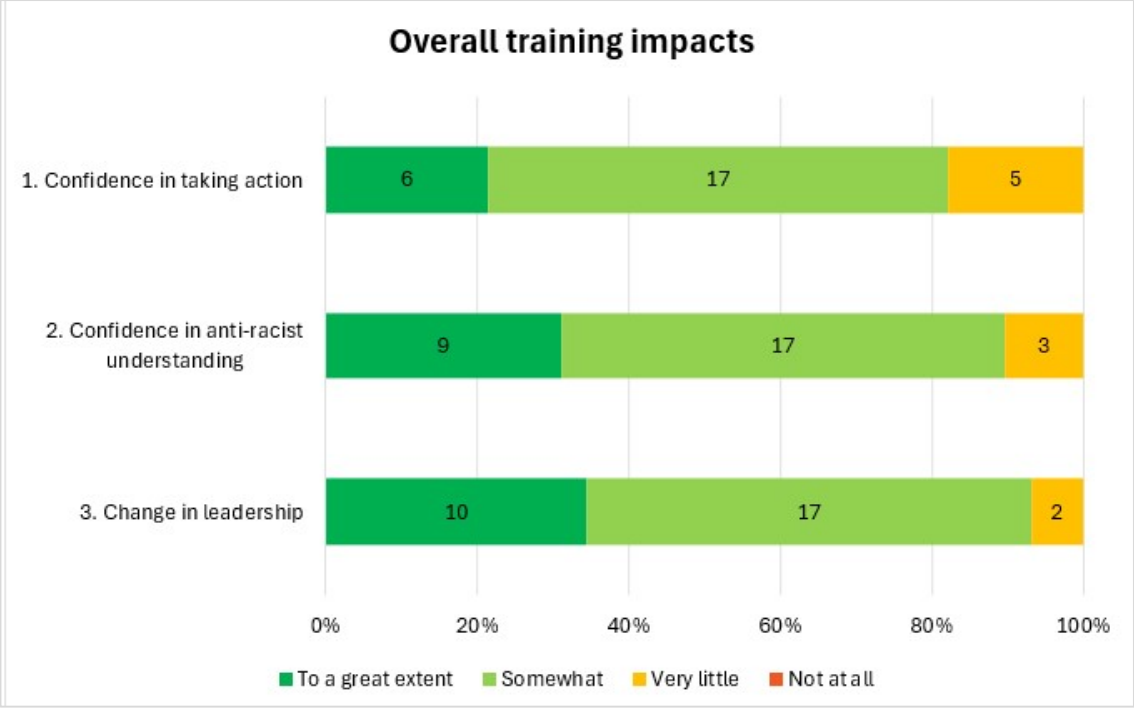
One participant said because of the training they had reached out to their wider networks to connect and collaborate, 'I have reached out to a colleague within the university and want to engage with wider anti racism work beyond my programme / immediate team / students. I will push for workload allocation for this too, so that I can dedicate meaningful amounts of time to this.'

Another participant said because of this training they were taking an active action in their organisation by taking on, 'a leadership role in EDI.'

### 3.4.3 Impact of the training

Figure 11 shows the participants views on the overall impact of the training. 82% of participants said they had to a great extent or somewhat felt confident in taking action as a result of the training and 90% of participants said they had "to a great extent" or "somewhat" noticed a change in the way that they lead (at individual, team or system level) since participating in the programme. 93% of participants said they to a greater extent or somewhat had confidence in anti-racist understanding.

*Figure 11 Self-assessed responses of impact of the training overall*

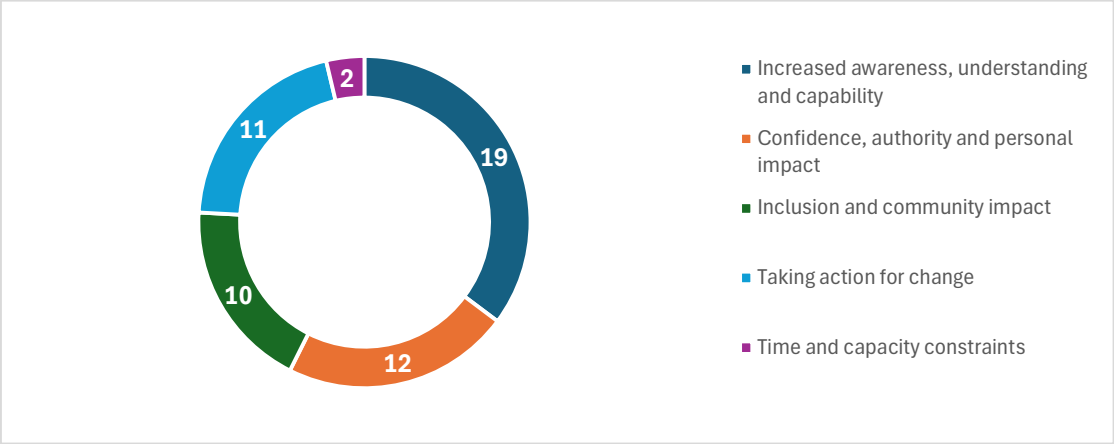



### 3.4.4 Changes in leadership style since the training

The participants were asked if they had noticed a change in the way that they lead (at individual, team or system level). N=27 (93%) participants said they had "to a great extent" or "somewhat" noticed a difference.

Participants were asked to give more information about the differences they had noticed in the way they lead following this training. This is a thematic analysis of the responses. There were n=23 participants that gave responses in SLT cohort 1 and 2.

*Figure 12 Pie Chart of thematic analysis (n=29) showing the self-reported changes in leadership since participating in the programme*




**Increased awareness, understanding and capability**

Most responses (n=19) cited an increase in awareness, understanding and capability in terms of anti-racist practice. Participants reflected on a transformative change in their level of understanding, and the impact this has had on their work individually and more widely. Participants wrote, ‘'[I] am more aware of my own potential unconscious biases and how they impact my approach to leading on work programmes', 'realising how much I didn't know has been, ironically, empowering... I now feel I have a better idea of where I might start to make a difference'. Another response notes, ‘I can't unknow what I now know'.

There was also reference to a change in levels of awareness, specifically becoming more conscious of systemic racism. Participants note, '[I] am more aware of cultural diversity and highlighting that as a positive to engage previously marginalised people', 'I feel much better able to spot racism all around me in society and the world, to which I was previously relatively blind not believing this to be true'. Two participants reflected on this from the lens of other colleagues, '[I] More aware of others’ places on the journey of learning about racism,' and '[I] am more aware of micro-aggressions, need for wider development and understanding amongst ward leaders.'

Participants highlighted the change in their level of capability, one participant shares feeling ‘much more equipped with the knowledge and skills to call out racism and also think much more about how we treat staff fairly’, echoed by another response which cites feeling 'much more confident in my language I choose to use and how to speak up when necessary'.

**Confidence, authority and personal impact**

Twelve responses received cited an increase in confidence following their participation in the BMM programme. This included feeling braver to be actively anti-racist, to participate in conversations about racism, and increased confidence in leadership ability. Of these responses, three also reflected on the impact of the programme on them

personally, expressing gratitude for the ways in which they have changed since participating.

Five responses cited feeling braver, one noted feeling ‘bolder and braver to raise anti-racism issues’, and another felt they had ‘learnt to question things more, to be more curious and be brave enough to challenge decisions’.

Two participants highlighted the sense of authority that the BMM programme has instilled, ‘I feel emboldened and authorised by being an alumni of the BMM anti racism training and can use this as a credential to back my passion’, echoed by another response, ‘I feel MUCH more informed so have a sense of authority in what I am saying’.

Specific references were also made to confidence in leadership ability, one participant shared that the programme ‘has made me a better leader'. This was echoed by other participants reflecting they feel ‘more confident in their ability to lead’ and feeling they ‘now have a better idea of where I might start to make more of a difference.’

Three participants expressed gratitude for having participated in the programme. One noted, ‘thank you for a brilliantly inspiring course. I felt every voice in the room mattered’ and went on to highlight the ‘emphasis on supporting us to understand and therefore make changes’. Another reflected on the way the course affected relationships, world view and confidence and ultimately feeling empowered to make change. They note ‘I feel motivated and hugely grateful to be part of this programme.’ Another noted that participating in the programme has made them ‘feel a better person’.

**Inclusion and community impact**

Ten responses made reference to understanding their privilege and a shift toward understanding the perspectives of marginalized communities.

Participants reflected on the impact of their work on individuals who are racially marginalised. One participant noted a conscious effort to 'see things through a lens of those racialized as black or brown and how any change will affect them and what improvements could be made (even small ones) that may have an impact on their care or even just how they feel’, another notes that they now 'try to ensure that marginalised groups are represented in our projects'. One participant reflects on the limitation of their own knowledge, and the desire to seek informed voices, ‘I acknowledge where my knowledge is lacking and others have greater expertise and seek those people out to work with us.’ Another participant expressed that their 'use of language is much more inclusive and considerate of different cultures.'

This intention extended to supporting colleagues, with one participant noting that they have 'given significant thought to my workforce and how I empower colleagues racialised as black or brown to take up leadership opportunities'.

Two participants make reference to their understanding of their own privilege, one acknowledges how this is a 'responsibility to accept privilege' and another noted that they are 'much more conscious of the privilege of my race'.

**Taking action for change**

Eleven responses referenced action taking as a change in their leadership since participating in the BMM programme. This included desire to share learnings with others and enact actionable changes.

Responses highlighted a desire to share their learnings more widely. Participants reflect on supporting the wider change, one participant referenced ‘ensuring people in my teams are aware of cultural variation and its impact on care’, and another noting ‘I actively seek opportunities to share this personally and professionally.’

Responses also reflected a higher likelihood to engage in conversations about racism. One participant felt 'more likely to engage in conversations about race and prejudice', echoed by another, who shared they had ‘more consciousness and speaking up or starting conversations around racism, facilitated by publicly reading the book-list.'

A sense of duty was also reflected within responses, one response highlighted a change in being ‘more directive about what we need to do as public servants in educating ourselves and our responsibilities to accept privilege and allow discomfort in conversations’. Another participant noted a change in ‘taking a more proactive stance.’

One participant referred to specific actions already taken, 'As a system leader I acknowledge this in all discussions at board level when we are discussing health inequalities etc and in particular ensuring I raise the profile of these issues within nursing, midwifery and AHP professionals'. They go on 'by acknowledging this I can then begin to lead much more effectively to develop career pathways and equitable recruitment of those from the global majority.'

**Time and capacity constraints**

Two participants noted time and capacity constraints as affecting their participation in the programme. One noted that they were unable to attend all book clubs due to clinical commitments, but 'those that I did attend were very thought provoking'. Another noted that they found it 'challenging to read the books in the timeframe'.

# 4. Discussion

## 4.1 Findings of this Evaluation

### Main Findings

Data showed many of the participants felt they had much higher levels of cultural competency following the training. They expressed they had become advocates and champions of anti-racism. Participants fed back they were comfortable directing their organisations to review or update policies. Knowledge is a key part of feeling capable to make a behaviour change and data showed an increase in knowledge in cultural competency. Qualitative feedback showed participants highlighted the sense of authority that the BMM programme has instilled, and that they feel empowered.

### Cultural Competency

This report found that the training was successful in increasing the cultural competency of attendees. The greatest changes were seen in cultural awareness; evidence of participants increased understanding of the biases they hold was found both in their questionnaire ratings and their qualitative feedback. Participants reflected on a level of understanding that was transformative, and the impact this has had on their work individually and in their environment. Participants' knowledge and skills about cultural competency also increased, but this increase was not as pronounced as their cultural awareness.

### Putting training into practice

The analysis showed that participants have the capability and the necessary relationships with their colleagues and managers to implement anti-racist leadership at work. Most participants rated their organisational leadership teams as relatively psychologically safe, and this was corroborated by the qualitative feedback which shows participants are able and willing to speak out and challenge unconscious bias.

Some participants felt they lacked the necessary time or resources to take action. Participants were left highly motivated to implement changes because of the training, but making changes is still not automatic for of them and will require thought and effort on their part. Even though some participants highlighted challenges with implementing changes, most participants (82%) felt confident with progressing with new anti-racist initiatives at work. These are wide ranging, and include delivering anti-racist training, changing organisational policy and practice, implementing new data collection and evaluation procedures to highlight racism, and championing/advocacy.

### Impacts of the training

Overall, the training was rated as useful and impactful. Participants have demonstrated ongoing action and commitment to anti-racist Practice. Participants took a range of different actions and described meaningful ways in which their leadership style had changed as a result of the training. Leaders are using their platforms to describe the

transformational impact that being a BMM participant has had on them as individuals and how this influences the way they lead.

## 4.2 How this evaluation adds to the knowledge of the programme team

This evaluation has highlighted a wide range of anti-racist activities being implemented by senior leaders who attended both cohorts. The programme team who are implementing BMM are aware of some of these larger initiatives. Notably, a Chief Executive of a large hospital trust has now commissioned a bespoke BMM programme, with a Senior Leader and Champion Cohort, and two virtual training cohorts. Participants have been vocal in expressing the "life changing transformation" that BMM has elicited and how the wider impacts of the learning are extending to family and friends.

However, the confidence to take action by such a large number of senior leaders (82%) was news to the BMM programme team and was further demonstrated in the qualitative feedback from participants. The programme team offer support for anti-racist quality improvement activities undertaken by BMM trainees and had anticipated that most anti-racist activities would be shared via these support mechanisms. A potential explanation for this is that transformation work in BMM (action taken during or post the 6-month training programme that contributes to implementing anti -racist culture change) has to date been categorised and described as “quality improvement”. There may be a disconnect in some participants in understanding that any work undertaken as a result of BMM is eligible for inclusion as a quality improvement project and reporting work to the BMM programme team.

## 4.3 Current cultural and social context

The changing political and social context of 2025 must be acknowledged in relation to delivery of this work. In 2021 there was a strong social appetite for anti-racist initiatives in the context of the MBRRACE-UK report and Black Lives Matter. A cultural shift has been observed since 2021, which may mean there is less investment and focus on anti-racist practice and training, however, this work is still relevant today. The influence of global moves towards dismantling EDI initiatives was noted in one Book Club session and this is a risk to continued buy in and spread. Despite this, reflections from participants reinforces evidence and the central foundation of BMM that whiteness is centred as the norm within NHS systems and structures. Participants are now equipped with knowledge to influence this within their sphere of leadership but will require ongoing support to achieve this.

## 4.4 Limitations of this Evaluation

This evaluation was limited to a post-training questionnaire designed to measure the impact of the training on the leaders who attended.

The training was not mandatory to and there is a potential risk of bias in the self-selecting sample of senior leaders who choose to attend. These leaders may be early adopters of

change while late adopters are typically resistant to change. As the original evaluation plan used matched pairs of participants, identifiers were requested from participants. This may have caused participants to be less authentic in their responses as they may have felt they could be identified. There may also be some level of response bias as it was not mandatory to complete the feedback questionnaire.

Nonetheless, there was a high response rate to the questionnaire, which limited the response bias. The findings from each section of the questionnaire corroborate each other and are further corroborated by the qualitative feedback, which adds strength to the conclusions.

# 5. Recommendations

**SLT BMM training is valuable and should be continued**

This evaluation reinforces the ongoing need for anti-racist theory and practice within perinatal and wider NHS systems. The acknowledgement by participants that this is a transformational experience in knowledge and skill acquisition adds further evidence to the need for BMM to continue to be provided at both SLT and perinatal levels.

**There is a continued need for ongoing support**

The BMM model is built on the foundations that this is a learning journey and not a single period of knowledge acquisition. One of the largest shifts in competency was the recognition of participants that anti-racist practice is a lifetime learning journey.

Reflections from participants reinforces the published evidence, and the central foundation of BMM that whiteness is centred as the norm within NHS systems and structures. Participants are now equipped with knowledge to influence this within their sphere of leadership, but they acknowledged that changing their behaviour to implement anti-racist leadership at work was not automatic. They will require ongoing support to achieve this through formalised communities of practice.

**The QI / transformation support needs to be communicated more clearly**

Feedback from participants demonstrates that there is a range of anti-racist transformation work being undertaken post training, but this not always communicated to the BMM Programme team. There is variation in participation of senior leaders in the ongoing virtual opportunities made available to support with Anti Racist QI and transformation. To ensure that there is increased engagement and improved communication for Senior Leader Alumni and the BMM Programme team, there is a need for the programme team to review the current communication and description of QI and transformation. This is in the context that Anti Racist QI is a new concept and there is a need to increase confidence in using the IHI Model for Improvement and associated methodologies with BMM participants. In addition, there is a need for a review of the current offer for Senior Leader participants including the language used to describe Anti Racist action taken within transformation and or QI work.

**The course promotion needs to be reviewed in the context of a change in culture**

The cultural shift towards dismantling EDI initiatives needs to be considered when promoting this work in future. There may be resistance from both commissioners and from potential future participants to engaging in anti-racist training. This should be

anticipated, addressed and the shifting political climate acknowledged in discussions with people who may not see the need for anti-racism training.

**Provide Book summaries**

Participants found the book club useful (93%) but some found it 'challenging to read the books in the timeframe'. This reflects the findings in previous cohorts, where not all participants attended the book clubs. Book summaries are an easy way to enable participants to get and overview of a book and enable them to attend a book club even if they have not finished the book.

**Implement steps to ensure high levels of questionnaire completion**

This evaluation, and any future evaluations of BMM depend on high rates of questionnaire completion. There was a higher response rate to Cohort 1 (84%) vs Cohort 2 (54%). This may because for cohort 1, an evaluator was present on the last day reminding attendees to complete a questionnaire. Similar steps for future cohorts are likely to significantly increase uptake and therefore the richness of any data available for evaluation. Previous questionnaires have asked for the names of attending individuals. Future questionnaires should be anonymous. This will negate the need for data linkage, minimise handling of personal data and may increase both uptake and candidness of responses.

**Future evaluations**

This evaluation has demonstrated the transformational impact that BMM has had on the senior leaders who completed the training and highlighted a range of anti-racist initiatives which have been initiated by these senior leaders. In the future, there is a need to investigate the impact of BMM at a system level: firstly, on whether there has been a change in care for women and babies racialised as black and brown across the system; and secondly on whether there has been a change in clinical outcomes and experience for women and babies in hospitals and Trusts where this change has occurred.

The sequencing of these evaluations is important. In any impact evaluation, it is essential to firstly understand the intervention, to document where it is deployed, and to develop a hypothesis, or programme theory, of how it will shift outcomes. It is therefore recommended that this descriptive and theory-based evaluation is completed before an impact evaluation is carried out.

Evaluating system-level change and clinical outcomes will take substantially more resource and planning than measuring direct impacts on the trainees. Any future wider-scope evaluations should be properly resourced and conducted in a planned manner underpinned by a clear programme theory or logic model.

**Conclusions**

This evaluation reinforces the ongoing need for anti-racist theory and practice within perinatal and wider NHS systems and has identified a number of actions for the programme team to improve the training for future cohorts.