West of England Academic Health Science Network

The Health Foundation

Evaluation Summary of the Black Maternity Matters Pilot

Authors: Genevieve Riley, Pete Aldridge, Nadia Taylor-Anjous and Shannon Roseveare

February 2023

Suggested citation

Riley G, Aldridge P, Taylor-Anjous N and Roseveare S, (2023). Evaluation Summary of the Black Maternity Matters Pilot. West of England Academic Health Science Network

Authors

Genevieve Riley[1], Pete Aldridge[2], Nadia Taylor-Anjous[2] and Shannon Roseveare[2]

Project dates

Project commenced: January 2022

Project report finalised: January 2023

Acknowledgements

The West of England AHSN would like to acknowledge and thank the following people for all their contributions to the evaluation and final reports: Noshin Menzies[1], Ann Remmers[1], Kay Haughton[1], Vanesther Hamer[1], Louise Fortune[1], Loubaba Mamluk[3], members of the Black Maternity Matters Steering Group[4] and the midwife champions, midwives and maternity support workers who attended the training and took part in the evaluation.

Affiliation

[1]West of England Academic Health Science Network, [2]Unity Insights, [3]NIHR ARC West, [4]Representation Matters, [4]BCohCo, [4]Black Mothers Matter, [4]North Bristol NHS Trust and [4]University Hospital Bristol & Weston NHS Foundation Trust.

Funding

The Black Maternity Matters evaluation was delivered by Evaluation & Insight team at the West of England Academic Health Science Network, with additional support from Unity Insights. The project received a delivery grant awarded by The Health Foundation.

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	

Contact Details

Genevieve Riley, Senior Programme Manager (Evaluation & Insight), West of England AHSN: genevieve.riley1@nhs.net

Contents

Key Evaluation Findings Summary

Finding 1: Training increased the self-perceived knowledge and skills of all participants

Key Points:

- Training participants had overestimated their cultural competency at the start of the training programme (Dunning-Kruger effect of cognitive bias).
- At the end of the training, all 11 participants showed an overwhelming increase in the knowledge and skills associated with cultural competency.

Finding 2: Key qualitative themes were identified about participants' learning

Key Points:

- Training participants increased their understanding of how racism impacts health inequalities, and 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 training participants felt this was part of a necessary journey.
- Branding the training as anti-racism work has the potential to prioritise the severity of the structural issues of racism and its consequences. It creates a bold statement but could feel too 'hard-hitting', so future cohorts may need to consider a balance in the use of language to describe the training.

Finding 3: Themes about the training as a catalyst for change & improvement

Key Points:

- The training helped participants improve key understanding, knowledge, and awareness of the impacts of racism. This has the potential to act as a catalyst for change of what they can do differently in their spaces and how to utilise their powers to make a difference.
- QI training should form an integrated aspect of the programme, alongside cultural competency insight training.
- To create change in systems, it was identified that different levels of staff should attend the training, to understand the issues.
- A Midwife Champion role was identified as being instrumental for delivery and peer support but needs to have appropriate internal support from organisations to be successful.
- The Midwife Champion should be those with either lived experience (from the perspective of race) or demonstrate a good understanding of the issues of racism.

Finding 4: Themes reflecting on the project structure & implementation locally

Key Points:

- The partnership between the AHSN, VSCE and health community was an integral aspect to the success of the project.
- The AHSN acted as a facilitator between health systems and community partners with important expertise and experience to tackle the health inequalities faced by Black women.
- Training should be extended to organisational & clinical leadership to enhance systems change in health settings.
- A programme such as this should be embedded in organisational priorities and strategies for Equality, Diversity and Inclusion (EDI).

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' (MBRRACE-UK[a]) showed that poor outcomes are higher for mothers and babies from Black and Asian ethnic groups, particularly 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. Stillbirth rates of Black and Black British babies are over twice those for White babies[b]. 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 are described as a "constellation of biases"[c]; systemic biases preventing women with complex or multiple problems receiving the care they need ante and postnatally. Unconscious bias, stereotyping and lack of diversity competency have the potential to result in health services that disadvantage women from non-White ethnic backgrounds.

The West of England has not yet developed a targeted, unified strategy to optimising outcomes for Black pregnant women and their babies. Where training and education is offered, maternity system staff are often left with no clear steps to test actionable and meaningful change within a supportive QI collaborative, offering coaching and peer support.

Pilot Background

The Black Maternity Matters (BMM) pilot project was designed and implemented using improvement methodology, which is a popular approach to conducting tests of change to support quality improvement in healthcare[d]. Using PDSA cycles in this way can help deliver improvements in patient care through a structured experimental approach to learning and tests of change.

The pilot was designed to deliver meaningful, actionable improvements to reduce inequity of outcomes for Black women within maternity systems through a collaborative QI approach. This included a regional QI collaborative of midwives and maternity support workers (MSWs) to support psychological safety, peer support and QI coaching. A key component of the pilot was the delivery of cultural competency and diversity fluency education 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 training and later aspects of implementing QI approaches in maternity systems form the basis for the evaluation focus.

Methods

Aims and Objectives

An independent mixed methods evaluation was undertaken of the pilot project to understand the impact of a Quality Improvement approach to deliver improvement in the outcomes for Black mothers in maternity systems. The primary evaluation aim was to understand the impact of the cultural competency training for midwives and MSWs from two hospital trusts in Bristol.

Our secondary aim was to document the experiences of the steering group collaboration to deliver a co-produced pilot between the NHS partners and VCSE stakeholders involved, and to identify the

[a] MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK | MBRRACE-UK | NPEU (ox.ac.uk)

[b] Risks of stillbirth and neonatal death with advancing gestation at term: A systematic review and meta-analysis of cohort studies of 15 million pregnancies | PLOS Medicine

[c] MBRRACE-UK_Maternal_Report_Dec_2020_v10_ONLINE_VERSION_1404.pdf (ox.ac.uk)

[d] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6465814/

strengths of this model, as well as enablers or any barriers to implementation. Specific evaluation questions included:

i) How can the Black Maternity Matters pilot project influence at systems levels and how effective was the proposed approach of cultural competency training with a QI focus on creating change?
ii) To what extent did the project bring about change in local settings?
iii) What influenced different levels of engagement from different partners (inc. ICBs, local leadership, maternity networks?
iv) Why does it work in some areas and not others?

Study design, setting, sampling and recruitment

The BMM training programme comprised of six facilitated sessions with two specialist trainers from the independent sector. Three training sessions were delivered face-to-face with a midwife and MSW cohort (n=14), with three additional 'book club' sessions interspersing the face-to-face sessions.

Pre and post-training a validated measure of cultural competency[e] was used (at baseline and 6 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 cultural competency training. At the end of the training programme (6 months), the measure was repeated by the training participants (achieving paired data sets n=11).

We conducted qualitative interviews to understand the experiences of the training cohort. All trainees were invited to participate (n=14). 2 dyad interviews (n=4) and 2 midwife champions interviews (n=2) were conducted. A purposive sample from the broader project implementation team and stakeholder involvement group were invited based on their role or organisations within the steering group to explore their experiences of the partnership project (n=8).

Data collection, management and analysis

The majority of interviews were performed using video conferencing software by the same evaluator (MS Teams n=10) with two conducted face-to-face. All were collected between October and November 2022. 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 the West of England AHSN. Interview guides were developed by evaluation team according to the evaluation aims and objectives. Questions were tailored to suit the respective roles/experiences, for example trainees, trainers, community organiser stakeholders and NHS partners.

Data were analysed inductively by three evaluators independently. A thematic structure to summarise and classify data was created using a coding framework linked to the interview questions, evaluation objectives and early analysis of interviews. Text was coded to represent themes and help facilitate exploration of the data from a range of participants. All evaluators met to discuss the coding framework at each step of the analysis to form a range of final themes and ensure rigour to the process.

Evaluation governance

The project was registered for QI and evaluation purposes with the Quality and Safety Improvement team at North Bristol NHS Trust. Oversight of how the evaluation was being conducted was delivered through the main programme board supporting the delivery. Valid informed consent was received from all training participants at the first stage of the programme, and during later stages of the evaluation, consent was received from all stakeholders taking part in interviews.

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

Key Findings

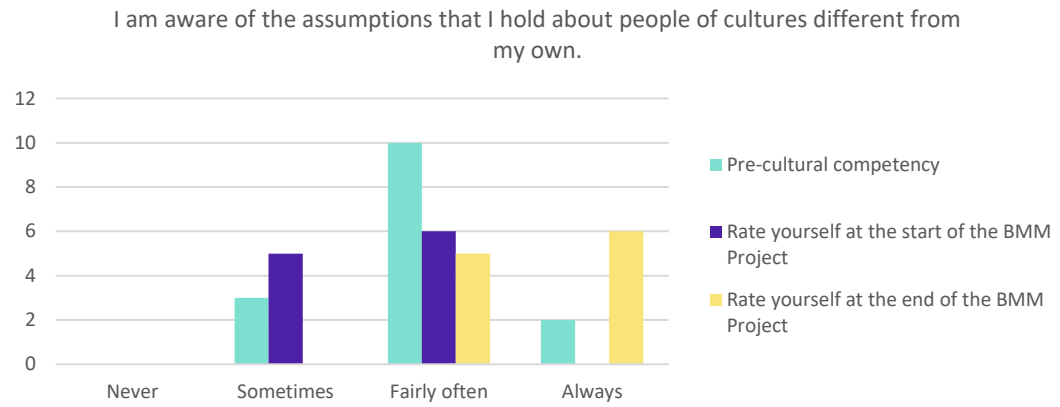
Finding 1: Training increased the self-perceived knowledge and skills of all participants

After using the cultural competency measure at baseline, a theme emerged early on in our analysis, that staff had self-rated their knowledge and skills before the course as 'relatively high' in all domains, which we had not predicted.

We identified 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 (figure 1).

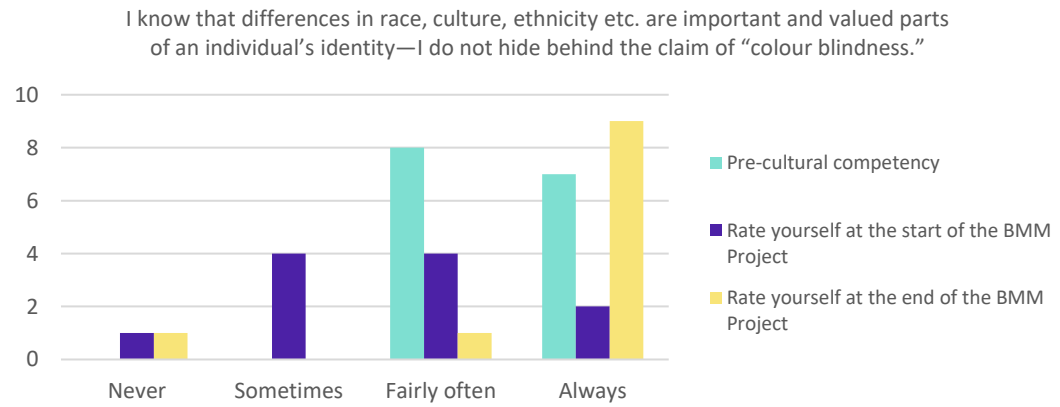
At the second measurement point (post-training) we asked staff to give two ratings. Having completed the training, we asked them to consider their baseline skills for a second time, but with the benefit of hindsight. Then we asked them to rate their knowledge and skills at the end of course.

Figure 1:



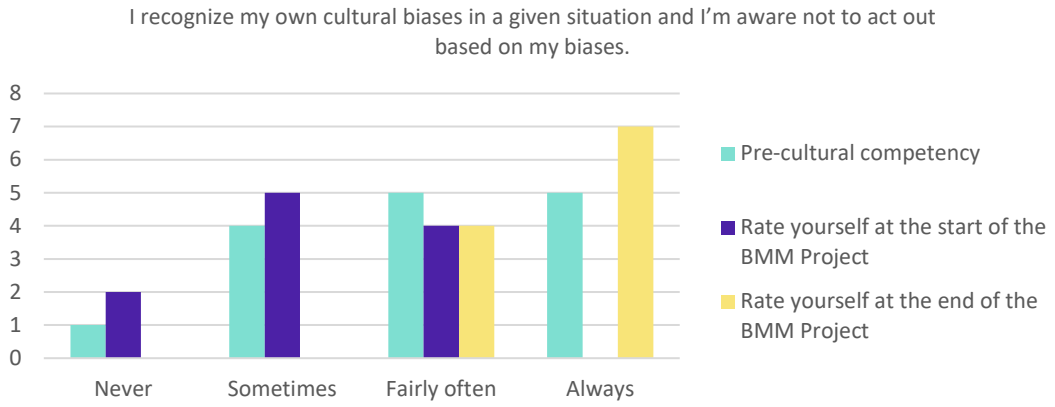
We were able to demonstrate a clear Dunning-Kruger effect of cognitive bias across 34 out of 36 areas of cultural competency. Staff had overrated their knowledge or skills at the start of the programme, but after completion they were able to reflect on how little they had really known at the start (figure 2) and 3.

Figure 2:



> *"I didn't know how to put it into words, just the most eye-opening transformative training ever is the best training I've ever been on. Hands down. Like it, it weaves its way into everything, and you can also apply it to things other than me. So looking at how we look after women with disabilities or gender identity, a lot of the stuff you're learning is actually just basic kind of kindness and think about listening and the way we talk and the way we speak. So it there's a lot of transferable information there as well." B010 and B013*

Figure 3:



Key Points:

- Training participants had overestimated their cultural competency at the start of the training programme (Dunning-Kruger effect of cognitive bias).
- At the end of the training, all 11 participants overwhelming showed an increase in the self-perceived knowledge and skills associated cultural competency.

Finding 2: Key qualitative themes were identified about participants learning

The need to confront bias in healthcare & how it relates to health inequalities

Throughout the training, participants have learned about structural issues of racism (figure 4). This appears to have effectively increased awareness of these issues and enabled participants to reflect on what they have learned in the context of their own work.

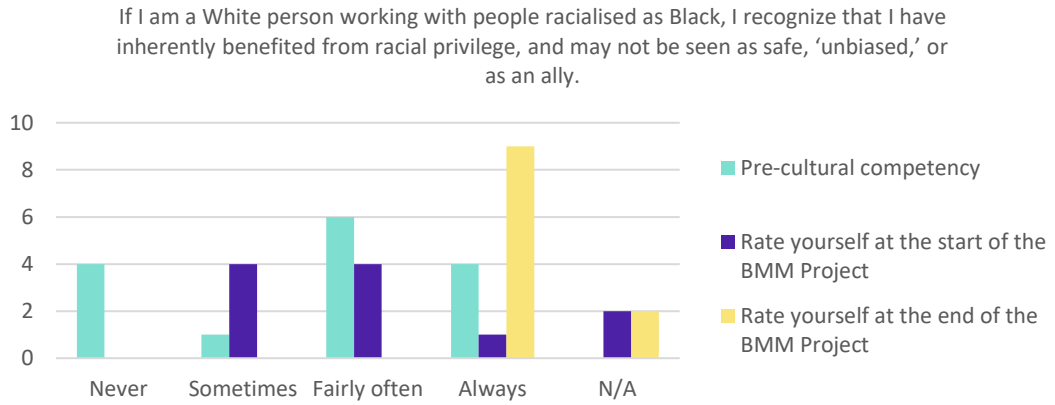
Training enabled the participants to recognise they had previously dissociated their knowledge of health inequalities in the context of race. Participants were also able to recognise institutional racism:

> *"I know that there are inequalities, but I hadn't really ever thought about them, hadn't had a hard think about why, also probably when thinking about the awful statistics, thinking oh yeah, but that's that doesn't happen, that doesn't happen where I work. So probably just you know thinking that that just happens in other tests where there is racism but no wouldn't happen at (Site A). Whereas yes, that's very, very wrong." B011*

Participants often gave examples of how an individual's behaviour can be deemed bias or racist. They were able to identify occurrences of unconscious bias in the work setting. They were taken on a journey of realisation and processing:

> *"As I think it's like she said… that a lot of it's unconscious. I think at the moment, we go along quite blindly thinking that actually in this country there isn't a real issue. I think that's coming from this standpoint of white privilege, which we talked about a lot in the course and the fact that it's unconscious. You know it's about bringing it into full consciousness, and I think that's what the course is done for all of us and what we now want to take forward and into our departments." B009*

Figure 4:



Learning in this way created discomfort – this needs to be taken in to account when planning & delivering training

Discomfort surrounding this area of work is acknowledged by most involved. Reactions to this discomfort differ. Some deem it as inevitable and necessary for learning and growth, others find the discomfort to have an emotive or negatively emotive impact, some reportedly react in a defensive manner. Having to work through this discomfort to get to a place of comfort, is the very essence of the programme.

Confronting bias can cause tension due to the variation of perspectives of issues and defensiveness. For example, when calling / defining behaviours as racist or bias. It's important to create a safe space when dealing with uncomfortable topics.

Course Framing and Identity

The identity of the training is specifically anti-racist, using this term highlights the severity of the issue and prioritises it. Using such branding of the training is a form of confronting bias in itself. Anti-racism branding is linked to uncomfortableness. As it creates a bold statement, reactions can vary.

Some of those involved praise this approach as it creates a stance against racism and doesn't hide / skirt around the issue. Others imply it can be too hard hitting, make people feel attacked, or offended.

However, it is noted that training participants became comfortable using the term throughout the training, and comfortable and bold when identifying racism:

> *"So I do think that if we went down the line of 'this is anti-racism' … you might not get as many people coming from different perspectives that might feel uncomfortable with the term racism. But I think as the project went on we definitely saw the shift in lots of people … they were comfortable using that term, and kind of identifying and saying this is racism … that word didn't feel like you can't say it, you're not choking up on saying the word because you don't want to say it, it's like actually, 'no, I'm going to be bold and call it what it is.'" B001*

Key Points:

- Training participants increased their understanding of how racism impacts health inequalities, and 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 training participants felt this was part of a necessary journey. Future courses should promote a strong focus on the training as a mechanism to address racism and be communicated as anti-racist training, as well as developing cultural competency in the workforce.
- Branding the training as anti-racism work has the potential to prioritise the severity of the structural issues of racism and its consequences. It creates a bold statement but could feel too 'hard-hitting', so future cohorts may need to consider a balance in the use of language to describe the training.

Finding 3: Key qualitative themes identified the training as a catalyst for change and improvement

The ability to create change needs to be embedded in the course structure

The course provided training participants with key understanding, knowledge, and awareness of the impacts of racism. This led to a will for change of what they can do differently in their spaces / how to utilise their powers to make a difference (figure 5 and 6).

This could include supporting colleagues, identifying and bringing attention to bias. Adapting, improving, and equalising standards and quality of care for all.

Specific examples from participants showed engagement in various ways. Insight shared by training participants framed how using their new knowledge from the training, confidence, empathy, and reassurance could make a woman feel more comfortable and ultimately removing barriers and improving her care and experience.

From the initial pilot project, it has been hard to show evidence of individual QI in the short-term. Some midwives noted that they know what they need to do but don't know how to act on it or organise it, felt like there may be barriers as a "normal midwife".

Figure 5:

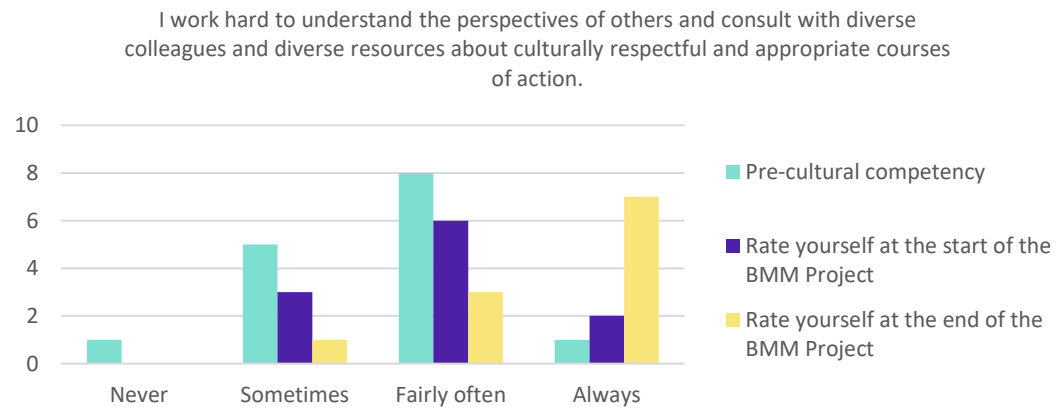
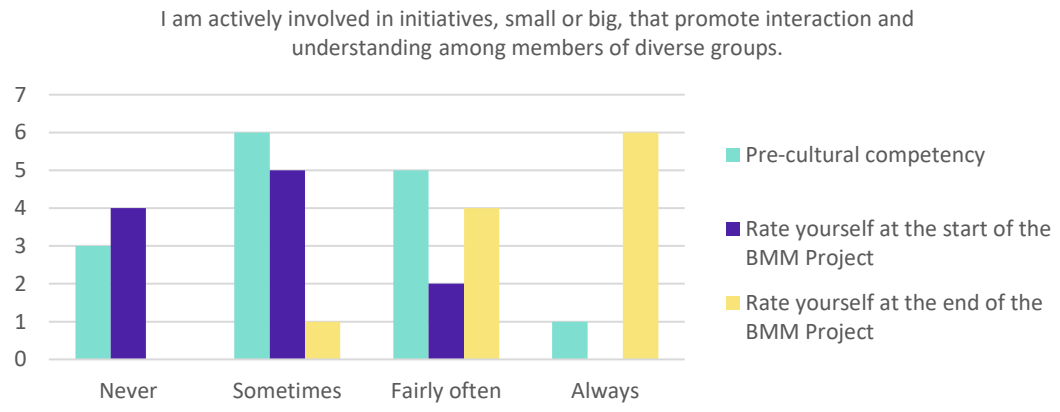


Figure 6:



Consider who should be attending this training

Different types of training participant attended, and these groups experienced the course differently, so thought should be given to identifying cohorts and bringing groups together to avoid creating divide in the training setting.

To maximise change and avoid blockage of progress in healthcare settings, training should penetrate all levels of hierarchy / combinations of staff, otherwise learnings and actions will only travel so far. A

combination of seniority levels is recommended to go through training; it was identified you cannot have operational staff without leadership/ strategic staff also experiencing the training because low level changes won't impact ingrained system issues in healthcare settings.

The Midwife Champion Role creates a sustainability focus

This role was identified as instrumental for peer support. The Midwife Champion was able to show how training works outside of session and keep motivation. This role was seen as crucial in succession planning, internal employees able to uphold training, advocating, and driving change for true legacy.

There were logistical problems with support and funding for champion role, the champions had to work additional hours that they had not received pay, impacting their ability to do role to the fullest. This has negatively impacted their experience of undertaking the role at times.

Suitability of candidates for the role of champion was discussed. Many stated that although being racialised as Black is not a prerequisite, those who fulfil the role in future cohorts should have to demonstrate a deep level of understanding of issues related to racism and health inequalities, as well as experience, and enthusiasm.

Key Points:

- Our training participants improved key understanding, knowledge, and awareness of the impacts of racism. This has the potential to act as a catalyst for change of what they can do differently in their spaces / how to utilise their powers to make a difference.
- QI training should form an integrated aspect of the programme, alongside cultural competency insight training
- To create change in systems, it was identified that different levels of staff should attend the training, to understand the issues.
- A Midwife Champion role was identified as being instrumental for delivery and peer support but needs to have appropriate internal support from organisations to be successful and sustainable for those doing the role.
- The Midwife Champion should be those with either lived experience (from the perspective of race) or demonstrate a good understanding of the issues raised in the course training.

Finding 4: Key qualitative themes reflecting on the project structure & implementation locally

Partnerships & the AHSN

Our evaluation identified that the support of the AHSN facilitated building a collaborative partnership to deliver a project with a clear agenda to support improving outcomes for Black mothers. Community partners reported it had previously been challenging to get engagement from healthcare systems to work with them to tackle the health inequalities faced by Black mothers.

> *"probably about six months prior to speaking to [AHSN contact], we've tried to start up conversations with the Trusts about unconscious bias and anti-racist training and patient safety, but actually got nowhere… working in collaboration with the AHSN gave us that kind of 'in' that was really hard to establish and I think if it hadn't been in collaboration, perhaps we may have been able to start a project like this, but it would have been in 10 years' time." B024*

The partnerships involved have reportedly been the driving force behind the programme and have complemented each other with a variety of knowledge and skills. The AHSNs involvement helped start the project promptly.

Focussing the potential of this programme

Many of those involved appreciated the longevity of the training, noting it allowed participants to process learnings and gave them time to reflect. But it is acknowledged that 6 days of training may place significant impact on services where operational staff are removed.

It was highlighted that this training should be extended to organisational & clinical leadership to enhance systems change. Although this may require different levels of training.

The possibilities for systems change through the facilitation of a programme such as Black Maternity Matters should be strategically aligned with health systems existing plans for patient-facing Equality, Diversity and Inclusion (EDI) structures and programmes. It was acknowledged that successful outcomes will be more likely when an intervention such as this fits with organisational priorities.

> *"But actually, if you have a collective of people within a particular environment making change, we can penetrate it at a much deeper level to get to the core root issues which are systemic racism. And then we could do much more to challenge the maternity system and make a difference to these women" B026*

Key Points:

- The partnership between the AHSN, VSCE and health community was an integral aspect of the success of the project
- The AHSN acted as a facilitator between health systems and community partners with important expertise and experience to tackle the health inequalities faced by Black women.
- Training should be extended to organisational & clinical leadership to enhance systems change in health settings
- A programme such as this should be embedded in organisation's priorities and strategies for Equality, Diversity and Inclusion.

Conclusions

The Black Maternity Matters pilot has demonstrated that anti-racist training has improved the knowledge and skills associated with cultural competency in midwives and MSWs. The evaluation has shown that training participants had overestimated their cultural competency at the start of the programme but by the end, they 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 the training as anti-racism work has the potential to prioritise the severity of the structural issues of racism and its consequences in healthcare, therefore future iterations of the training should be clearly identified as anti-racism work. This training helped participants 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.

The partnership between the AHSN, VSCE and health community was an integral aspect to the success of the project, whereby the AHSN acted as a facilitator between health systems and community partners with important expertise and experience to tackle the health inequalities faced by Black women. Future evaluation should encompass a focus on indicators and outcomes that address the health inequalities faced by Black women and which can be evidenced by local systems.

Black Maternity MATTERS

West of England Academic Health Science Network

Transforming lives through innovation

www.weahsn.net