North Central and East London (NCEL) Perinatal Provider Collaborative

Strategic Health Needs Assessment

Perinatal Provider Collaborative

NCEL Perinatal Provider Collaborative Strategic Health Needs Assessment

Contents

Acknowledgements
Thank you to all the parents and professionals across North Central and East London who shared their expertise, experience and ideas to support the development of this Strategic Health Needs Assessment.

A note on language

Inclusivity is a core value of NCEL Perinatal Provider Collaborative and Anna Freud. We recognise that families come in all shapes and sizes. When we say 'mothers' and 'women', we are referring to all people who have given birth or will give birth. When we say 'parents', we are referring to parents, carers and guardians.

We recognise that while the terms 'race' and 'ethnicity' are sometimes used interchangeably in policy and service provision, they are distinct constructs. In this report, the use of these terms reflects the language commonly used in the data sources.

List of abbreviations

Abbreviation	Definition
CQUIN	Commissioning for Quality and Innovation
ELFT	East London NHS Foundation Trust
ICB	Integrated Care Board
MBU	Mother and Baby Unit
MHA	Mental Health Act 1983
NCL	North Central London
NCEL	North Central and East London
NEL	North East London
NELFT	North East London NHS Foundation Trust
NLFT	North London NHS Foundation Trust
Perinatal PC	Perinatal Provider Collaborative
PMH	Perinatal mental health
PPIMHS	Perinatal Parent Infant Mental Health Service
SHNA	Strategic Health Needs Assessment
SPMHS	Specialist Perinatal Mental Health Services

Key messages

Introduction

The North Central & East London (NCEL) Perinatal Provider Collaborative (PC) brings together moderate to severe perinatal mental health services to improve the care pathway for women, birthing people and babies. Key aims of the Perinatal PC include a reduction in health inequalities and unwarranted variation in clinical practice, and effective use of resources, achieved through greater collaboration and amplification of service user voice.

This Strategic Health Needs Assessment (SHNA) was conducted by Anna Freud on behalf of the NCEL Perinatal PC between September and December 2024. It brings together quantitative and qualitative data from across 13 London boroughs, five Specialist Perinatal Mental Health Services (SPMHS) and the East London Mother and Baby Unit (MBU) to explore local needs and service provision. It presents a set of co-produced recommendations designed to support and enhance the work of the Perinatal PC.

What are the key messages?

Local population profile and access to service provision

There is significant ethnic diversity across the boroughs served by the SPMHSs and MBU. Data suggests that compared to the population, proportionally more Asian or Asian British people and proportionally fewer White people are giving birth. The available data indicates that in some areas, the number of women from Asian, Black, Mixed, Other and White ethnicities seen by SPMHSs is broadly proportionate to the ethnic profile of local populations of childbearing women, and in other areas there are disparities. Whilst the large scale of this SHNA and gaps in quantitative data limit the specificity of findings on ethnicity and service use, feedback from local parents and professionals identified specific ethnic groups within those five broad categories who are not accessing services. The analysis presented here provides a foundation from which to take forward further investigation, through the rigorous collection and interrogation of individual service-level data.

A third of women admitted to the East London MBU between April 2023 and March 2024 had a Black or Black British ethnicity, while this group comprised only 11% of those who gave birth in the same period. The largest proportion of admissions to the MBU under the Mental Health Act (MHA) were of Asian and Black patients. These are concerning findings and may be related to a number of factors that limit Black and Asian women's access to and engagement with preventative support, including discrimination and racism, cultural attitudes to mental health and getting help, and a lack of knowledge about available services.

There is significant deprivation across the Perinatal PC footprint, with between two and three boroughs in each Trust experiencing higher-than-average levels of deprivation. Trust-level NHS England data from July 2024 shows that between 23% and 35% of women on SPMHSs caseloads live in the most deprived areas of the region, but more detailed data from individual services would help to identify local access rates for women from deprived areas. Women who live in the most deprived areas of the Perinatal PC footprint were more likely to be admitted to the MBU than those living in more affluent areas.

While the rate of conceptions of teenagers aged 15-17 years has been falling since 2018 across London, Waltham Forest, Havering and Camden have seen a recent increase. In Haringey, Enfield, Havering, Barking & Dagenham and Newham, the number of child/teenage mothers (aged 12-17 years) is higher than the London average. Improved quantitative and qualitative data on young women's use of services would provide a fuller picture of service accessibility to young parents.

The available data suggests that between 2% and 10% of people living in the Perinatal PC footprint identify as lesbian, gay or bisexual (LGB+). Compared to the average for England, higher proportions of London residents do not identify as their sex registered at birth. LGBTQ+ people are at high risk of experiencing perinatal mental health difficulties, yet data on gender identity and sexuality is not routinely collected by services which makes it difficult to know whether and which people within this diverse community are being supported.

Local SPMHSs are grappling with implementing NHS Long Term Plan requirements around the assessment and signposting of fathers and partners of women receiving care. Support for fathers and partners was a priority for the local parents to whom we spoke. It was felt that fathers are not routinely included in physical or mental health support provided to women during the perinatal period, leaving them feeling isolated and contributing to pressure on women's mental health and the couple's relationship.

Improvements in multi-agency processes and relationships

This report highlights pinch points in the system where barriers to effective pathways between services occur. These include challenges with the referral process into the MBU, variable involvement of SPMHSs in patients' care whilst on the ward and limited join up between the MBU and other acute female in-patient provision.

Professionals reported more effective join up between the ELFT SPMHSs and the MBU, facilitated by existing professional relationships and geographical proximity rather than formal processes. Service-level data indicates that more women from ELFT boroughs are admitted to the MBU than from other boroughs. Whilst this may be partly explained by a particularly high prevalence of risk factors in the population in ELFT, these findings need continued monitoring and exploration, in conjunction with an open dialogue between service provider NHS Trusts to

understand and address any ongoing concerns about power imbalance and inequity in the Perinatal PC.

Parent voice and community outreach

A central message from local parents was the importance of services 'reaching in' to communities via targeted outreach work and enabling parents to 'reach out' through better promotion of services and a focus on reducing stigma associated with mental health difficulties. Parents told us that there is limited knowledge about available services and how to access help in local communities. They talked about the importance of being met with empathy and respect when help seeking and valued an individualised approach to care.

Participation is recognised across the Perinatal PC as a key driver in reducing health inequalities. ELFT has a strong perinatal participation workstream and there is appetite for increased co-production and peer support offers in the other Trusts. Outcomes data is another mechanism for hearing and responding to service users' voices. Data is being recorded for a minority of service users and greater use of standardised and routine outcome measures across services would be a source of rich data on impact, particularly if linked with data on demographics and social risk factors.

Enabling community provision to support alternatives to admission

One aim of the Perinatal PC is to support alternatives to in-patient admission where clinically appropriate, which means a focus on enabling community provision to provide intensive support. There has been an increase in the number of referrals and the number of women being treated by SPMHSs, particularly in NLFT and ELFT, and services are working towards, or have achieved, the target set by NHS England for 10% of the birthing population to have access to a SPMHS.

The data from the MBU suggests that acuity on the ward has grown and there has been a gradual increase in the number of patients admitted under the MHA over the last three years. This raises important questions. Does the higher level of acuity on the MBU reflect improved community care for women, meaning that only those with the most severe needs are admitted? Does this suggest that more could be done to identify and respond to emerging perinatal mental health difficulties at an earlier stage? Is acuity in mental health conditions rising in the general population, and therefore in the MBU, in response to societal factors like poverty and the cost-of-living crisis, poor living conditions and increased inequality?

Perinatal PCs are also tasked with ensuring equitable access to services. This report identified inequities in the types of services provided within the SPMHSs, including variation in the availability of intensive pathways, parent-infant relationship support and the provision of services for women with babies up to 24 months. These appear to be in part the consequence of disparities in available funding and staffing challenges, and it is hoped that the information presented in this SHNA provides a stepping stone from which to inform future funding decisions. However, it is also critical to keep in mind the importance of a place-based

approach, in which the diversity in demographic, health and social population profiles is understood and responded to.

A well-equipped workforce

With an increase in acuity in the MBU and a continued push to provide earlier intervention and improve access, the need for a well-equipped and confident workforce is clear. There is a strong desire amongst the specialist workforce for increased training opportunities, including in-depth training on perinatal mental health, working with diverse community groups and trauma-informed care. They felt there was also a need for training of the wider workforce on perinatal mental health, including health visitors, midwives and GPs, to drive forward more effective early intervention.

Recommendations

1. Address limited community awareness of perinatal mental health services and seek to reduce stigma around accessing services. *Service user priority*

- Includes actions at a universal and targeted level to promote services and reduce stigma.

2. Upskill the specialist and wider workforce in perinatal mental health difficulties. *Service user priority*

- Includes training for specialist and non-specialist staff.

3. Develop approaches to engaging fathers and partners through collaboration and sharing of learning across the Perinatal PC. *Service user priority*

- Includes a fathers' and partners' working group, Community of Practice or similar model, and the development of services with fathers and partners.

4. Review and prioritise areas for development in service delivery with a focus on reducing inequity and develop action plans.

- Includes: improving the quality of food, collaborative care planning ***service user priorities*** and provision for babies in the MBU; addressing inequity in service provision within SPMHSs; improving inpatient care for women whose babies are removed from their care.

5. Carry out targeted outreach work to engage with specific ethnic groups.

- Includes actions to facilitate the comprehensive collection and analysis of ethnicity data from service users, and outreach work designed with the community.

6. Improve pathways and collaboration between services.

- Includes: reviewing MBU referrals system, developing a standardised set of referral criteria and resources for referrers; developing of an MBU in-reach, out-reach service; and prioritising relationship-building across specialist services.

7. Develop capacity for co-production in specialist perinatal services.

- Includes making the case for a dedicated perinatal peer support worker in each Trust, workforce training on co-production and increasing peer support capacity.

8. Strengthening data to inform service provision.

- Includes ensuring the routine collection of key data, exploring additional demographic data collection and considering key research questions.

9. Conduct a deep dive into the accessibility of services to LGBTQ+ birthing people and families.

- Includes hearing the perspectives of local LGBTQ+ families, improving data collection and developing a Perinatal PC-wide approach to inclusive practice.

Introduction

Key messages

- Perinatal mental health (PMH) problems are those which occur during pregnancy or in the first year following the birth of a child, including depression, anxiety and postpartum psychosis. One in four women and birthing people are affected.
- Risk factors for PMH include: a history of mental ill health, traumatic birth or pregnancy, domestic abuse, substance abuse, being a young mother, belonging to an minoritised ethnic group, being an LGBTQ+ parent and being neurodiverse.
- Certain groups are less likely to ask for and receive support for PMH difficulties, including women from minoritised ethnic backgrounds, fathers, younger mothers and LGBTQ+ parents.
- Key national strategies and action plans include: Five Year Forward View for Mental Health, NHS long term plan and three-year delivery plan for maternity and neonatal services, and the MBRRACE-UK Saving Lives.
- Specialist perinatal mental health services (SPMHS) and Mother and Baby Units (MBUs) provide specialist services for women who are experiencing moderate to severe PMH problems.
- NHS-Led Provider Collaboratives facilitate collaboration across NHS Trusts, aiming to standardise clinical practice and outcomes, reduce health inequalities and use resources more effectively.
- North Central and East London (NCEL) Perinatal Provider Collaborative (PC) includes the East London MBU and five SPMHSs and aims to improve provision of PMH support in the local area.

What is perinatal mental health and why is it important?

Mental health difficulties during pregnancy and the first year of a baby's life (also known as the perinatal period) are common and affect mothers, fathers and partners. They can include depression and anxiety, post-traumatic stress disorder (PTSD) and postpartum psychosis. For some, the severity of these difficulties mean they require specialist support, either through a specialist perinatal mental health team or in hospital within a Mother and Baby Unit (MBU).

Mental health difficulties can have long-term adverse effects on a mother's wellbeing, self-esteem and relationships[1,2,3]. They can also impact on their capacity to provide nurturing, sensitive care to babies[4,5], which can affect a child's emotional, cognitive and physical development[3,6,7,8]. Despite the significant impact of perinatal mental health problems, many women struggle to access timely support. Supporting babies', parents', carers and other family members' wellbeing supports lifelong good mental health, positive relationships, a strong economy and a compassionate society[9].

Prevalence of difficulties and inequalities

1 in 4 women will develop a mental health problem during pregnancy or within a year of giving birth, the most common of these being depression and anxiety[10]. Severe mental health problems, such as postpartum psychosis, can affect between 1 in 1000 women[11]. Additionally, around 25,000 women a year will experience PTSD following birth and baby loss[12]. Tragically, rates of self-harm and suicide are higher in mothers with mental health difficulties and poor mental health is the leading cause of death occurring between six weeks and a year after the end of pregnancy, accounting for nearly 40% of deaths within this time period[3,13]. Prevalence of perinatal mental health problems may be even higher in women from minoritised ethnic groups, young mothers and those living in low socioeconomic circumstances[12].

Perinatal mental health difficulties can also affect fathers and partners, with 5-10% experiencing perinatal depression and 5-15% reporting perinatal anxiety[14]. This prevalence can increase when the mother is also experiencing a mental health problem in the perinatal period[14].

Risk factors for perinatal mental health difficulties

Whilst anyone can experience a perinatal mental health problem, there are risk factors that make it more likely. These can be personal, such as a traumatic birth or pregnancy, or related to wider social factors, such as social and economic deprivation. Risk factors include:

- A history of mental ill health or preexisting mental health conditions, especially during pregnancy[15,16].
- Experiencing a traumatic birth or pregnancy, or a previous miscarriage or baby loss, with 16% of women continuing to exhibit PTSD symptoms nine months following their baby loss[12,17]. For fathers and partners, a traumatic birth increased their risk for anxiety, depression and PTSD, triggering feelings of guilt and helplessness[18].
- A younger maternal age, with depression up to twice as prevalent in teenage mothers compared to those over 20[19,20,21,22]. Young mothers may have more exposure to adverse childhood experiences (ACEs), such as abuse and social/economic disadvantage, or may have experienced disruptions to their education, all of which increase the risk of experiencing mental ill health[19,21].
- Experiencing domestic abuse[23], with women experiencing domestic abuse during pregnancy being three times more at risk for depression in the postnatal period[23].
- Wider social factors such as living in poverty, poor housing and socioeconomic status can also impact perinatal mental health[15,24].
- Being from a minoritised ethnic group[24]. Maternal mortality rates are higher amongst women from Black and Asian ethnic backgrounds compared to White women[13]. Barriers to accessing timely care are pronounced for women from minoritised ethnic groups, leading to worse outcomes[24]. This is further compounded by: different cultural understandings and stigma related to

mental illness, inequalities in socioeconomic status, wealth and living standards, and provider discrimination[25,26].

- Being a migrant, particularly those with an insecure immigration status[27]. Whilst research findings vary, anxiety and PTSD may be higher amongst migrant women. This may be exacerbated by social isolation, unfamiliarity with health systems and having English as a second language[27].
- Being an LGBTQ+ parent, for whom there is a higher risk for perinatal depression and anxiety compared with cisgender and heterosexual individuals[28,29]. PTSD following birth may also be higher in this community[28,29]. LGBTQ+ individuals may face fear and stigma, a lack of social support and find navigating the gendered system stressful, all of which may contribute to or exacerbate mental health problems.
- Neurodivergent conditions, including Autism (ASC) and Attention-Deficit/Hyperactivity Disorder (ADHD). The unique challenges of the perinatal period, such as changes to daily routines, hormonal fluctuations and poor sleep, can exacerbate vulnerability to mental health difficulties[30]. In the UK, the estimated prevalence of ASD in adults is about 1.1%[31]. Historically, women and girls have been misdiagnosed or underdiagnosed for both Autism and ADHD, particularly those from minoritised ethnic groups.

Inequality in access to perinatal mental health support

There can be many barriers to seeking professional support for perinatal mental health problems, such as fear or stigma, a lack of awareness of available support, or difficulty accessing services due to distance or long waiting lists[32,33]. Facilitators to help-seeking are continuity of care, a relationship with a trusted professional and a service which is individualised and culturally sensitive. Health professionals should be warm, non-judgmental and representative of different communities. Peer support workers are a welcome addition to a service and help to validate experiences.[32,33]

Research has shown that barriers are more pronounced for women from Black, Asian and White Other ethnic backgrounds. They have poorer access to perinatal mental health support in the community and are more likely to be detained in hospital (on an involuntary admission)[26]. Additionally, women from minoritised ethnic groups are less likely to have their symptoms identified[34], be referred for support[24] and to access treatment[26]. They are also less likely to report their symptoms to health professionals[24].

At the heart of these barriers is the racism some women and birthing people experience from healthcare workers and wider society,[35] as well as different cultural understandings of mental illness and different social or cultural norms relating to maternity[26]. As a result, mental health outcomes for women from minoritised ethnic groups are worse, with higher risk of maternal mortality[13].

Research with Muslim women suggests they have poorer experiences of maternity services, particularly those whose first language isn't English, and experience care

as insensitive and culturally inappropriate, with a lack of awareness as to how their faith impacts on their experience of maternity[36,37].

Generally, there is a need for further data on the use of perinatal mental health services by women in different ethnic and religious groups. Given the higher prevalence of perinatal mental health issues in these groups, coupled with the higher rates of hospital admissions, early identification and timely, targeted interventions is key[26].

Fathers report barriers to seeking help for perinatal mental health difficulties, such as a lack of awareness of available support, stigma and exclusion from services[38]. For many, self-stigma and notions of needing to be the "strong provider" meant they found it difficult to recognise and discuss when they were struggling. Facilitators to seeking help were peer support, having supportive professionals who asked about their wellbeing and having a say on decisions related to their partner or baby's care[38].

Younger mothers, particularly teenage mothers, face a multitude of complexities which can lead to adverse outcomes and impact their mental health[21,39]. These complexities make it harder for them to access support from services. They are concerned with being judged as a "bad mum" and are fearful of the involvement of social services. Additional practical complexities, such as needing to balance appointments with education, or the costs of travelling to services, compound these barriers. For younger mothers, home visits, flexible appointments and a trusting, consistent relationship were key to facilitating sharing of needs.

The experiences of LGBTQ+ parents are underheard. Individuals have described the importance of gender affirming care, with gender inclusive resources and professionals who are knowledgeable and sensitive[28,40]. Often LGBTQ+ individuals face significant inequities in accessing care for mental health, which focuses typically on heterosexual people and couples. For some, experiences of prejudice and discrimination had traumatised them and deterred them from seeking help. Help instead is accessed through peer support and online blogs and information.[28]

Neurodiverse parents can struggle to access appropriate mental health support during the perinatal period and evidence suggests that there is limited provision of neurodiversity-affirming practices in perinatal mental health services[41]. Neurodiversity often goes unrecognised and studies of autism in adults have shown that up to 80% of people have experienced a difficulty in obtaining a diagnosis, and many adults will not have received a formal diagnosis[42].

Policy context

There are several key national and local strategies and action plans on supporting perinatal mental health.

At a national level, the **'Five Year Forward View for Mental Health'**, identifies the need to improve perinatal mental health (PNMH) as a strategic priority for the

National Health Service (NHS)[43]. Between January and December 2021, 40,411 pregnant women and new mothers had contact with PMH services compared to the NHS target of at least 57,000.[44] The target for 2023/24 is that at least 66,000 women with moderate/complex to severe PMH difficulties should have access to care and support in the community.[45]

The **NHS Long Term Plan** highlights maternal mental health and mortality as a key concern and commits to improving the access to and quality of perinatal mental health care, particularly for those with moderate to severe perinatal mental health difficulties, including evidence-based psychological therapies, parent-infant, couple and family interventions and specific support for fathers/partners[46].

The NHS three-year delivery plan for maternity and neonatal services sets out a plan for ensuring maternity and neonatal care is equitable, safe and personalised to meet the needs of women, babies and families[47]. Key commitments were commissioning and rolling out more specialist perinatal mental health services, offering women personalised care plans to account for their mental health and social complexities, and improving equitable access through improving availability of mental health care.

The 2024 **MBRRACE-UK Saving Lives, Improving Mothers' Care** report provides data on the deaths of women and babies during pregnancy or shortly after pregnancy in the UK[13]. This update found rates of maternal deaths have increased significantly, with deaths linked to poor mental health, including suicide, being the leading cause of deaths between six weeks and one year after pregnancy.

T**he Birth Trauma Inquiry** (published in 2024) flagged the absence of a unified strategy for supporting those who have experienced traumatic births and an urgent need for a shift in the provision of maternity services[48].

The **Marmot review** into health inequalities in England drew attention to the social determinants of health, including housing, income, education, social isolation and disability[49]. A key priority was “giving every child the best start in life” as crucial in reducing health inequalities across the life span.

Family hubs offer a whole-family approach to community support. The **Start for Life** programme, embedded within the family hubs policy, offers preventative, early intervention for families during these crucial first years.[50] Nine of the 13 NCEL Perinatal PC boroughs were pre-selected for Family Hubs funding in 2021, which included funding for support with mild-moderate perinatal mental health difficulties and support for parent-infant relationship difficulties.

In terms of **local policies**, NLFT[51], ELFT[52] and NELFT[53] have Community Mental Health Transformation Programmes, which aims to bring together local services to support people with severe mental health problems. They plan to recruit additional staff, develop multi-agency teams (such as Mental Health & Wellness Teams) and increase access to psychological therapies.

Local need relating to perinatal mental illness are highlighted in some available Joint Strategic Needs Assessments (JSNAs) in the thirteen boroughs. These include, for example, in Islington[54], Hackney[55] and Newham's[56] Children and Young People's JSNAs, in Tower Hamlets[57] and Enfield's[58] Maternity JSNAs and as part of Havering's[59] Starting Well JSNA chapter.

Service provision for specialist perinatal mental health difficulties

Over the last 12 years, the government has increased the availability of specialist perinatal mental health services (SPMHS) and parent-infant relationship support for women experiencing severe mental health problems[12]. These teams provide assessments and psychological and social interventions[60] and are expected to deliver support for women in pregnancy and 2 years after birth.

In 2019, provision was expanded to included Maternal Mental Health Services (MMHS) in every area of England, which aimed to plug the gap between these SPMHS, maternity services and NHS Talking Therapies[12]. These services focus on birth trauma, severe fear of childbirth and perinatal loss. They offer support up to two years after birth.

Alongside these community services are Mother and Baby Units (MBUs), specialist, in-patient units for women during the perinatal period who are experiencing severe mental health problems (such as postpartum psychosis, bipolar disorder or schizophrenia)[61]. They are designed to keep mothers and babies together, facilitating the mother infant relationship, whilst offering support from specialist professionals. MBUs have been found to improve outcomes for maternal mental health and mother-infant relationships.[62] MBUs work alongside community perinatal mental health teams, maternity services and health visitors.

Women can be admitted to an MBU on a voluntary basis (subject to partner consent) through assessment by a mental health professional or can be admitted under the Mental Health Act if requiring emergency psychiatric care. Women can also be placed at MBUs out of area, in response to their preferred location of MBU or if beds aren't available at their local MBU, mothers may be admitted out of area. Other treatment options are admission to a general psychiatric ward. This poses disadvantages as mothers are separated from their baby which impacts bonding and can pose a risk to infant development.

NICE guidelines state that women referred to an SPMHS should be 'assessed for treatment within 2 weeks of referral and receive psychological interventions within 1 month of assessment'[63]. Women who have suspected severe mental illness should be referred to specialist perinatal mental health services, and for those with sudden onset of postpartum psychosis, assessment for admission to the MBU should take place within 4 hours of referral.

Service specifications for SPMHS and MBUs include the following outcomes: ensuring women have access to early advice and information on the risks of pregnancy and childbirth on their mental health, delivering a timely service and follow-up with a specialist community team following psychiatric admission[64]. For the MBU, they call for a reduction in readmissions within one month of discharge, a reduction in delayed discharges and a reduction in the mean length of stay. Treatment should be inclusive, integrated and comprehensive, and staffed by those with the appropriate skills and knowledge[64].

NHS England has developed these services further, through driving its ambition to see women up to two years postpartum, to provide assessments for fathers and partners and improving access to psychological therapies[46]. By 2023/24, the ambition was for at least 66,000 women to receive specialist care and support in the community, which established the target for SPMHSs to treat 10% of the birthing population.

The Provider Collaborative model

NHS-Led Provider Collaboratives are a relatively new approach to commissioning specialised mental health, learning disability and autism services. They formalise collaboration across NHS Trusts with aims of a reduction of unwarranted variation in clinical practice and outcomes, reduction in health inequalities, better workforce planning and more effective use in resources[65]. They also seek to support the system to find alternatives to in-patient admission, where clinically appropriate.

The Perinatal Provider Collaborative (PC) model is relatively new, and as such there is little reported on the impact of these partnerships at present. In London, Central and North West London (CNWL) and West London NHS Trusts (WLMHT) formed the North West London Perinatal Mental Health Provider Collaborative in April 2024 around the Coombe Wood MBU[66]. CNWL and WLT have previously worked together, in jointly providing the Maternity Trauma and Loss Care (MTLC) Service, which supports women/birthing people with a severe fear of childbirth, birth trauma or baby loss.

In South London, the South London Mental Health and Community Partnership (SLP) hosts the PPC, a collaboration of three South London mental health Trusts (Oxleas, South London and Maudsley and South West London and St George's)[67]. The SLP CAMHS Collaborative has been praised for its innovative approaches, from provision of Dialectical Behaviour Therapy (DBT) to their Family Ambassadors programme, which has improved engagement with parents and families[68]. Initial impact data has shown a reduction in A&E attendances, as well as de-escalating crises and a reduction in out of area inpatient treatment[67].

NCEL specialist perinatal mental health service provision

The North Central and East London (NCEL) Perinatal Provider Collaborative (PC) brings together East London NHS Trust (ELFT), North East London NHS Trust (NELFT) and North London NHS Trust (NLFT) to work together to improve the

provision of specialist perinatal mental health services in the area. The lead provider for the Perinatal PC is ELFT.

Service provision includes the East London MBU (based in City and Hackney Centre for Mental Health) and five SPMHSs across the three NHS Trusts. These are Newham SPMHS, Tower Hamlets SPMHS and City & Hackney SPMHS (ELFT); the NELFT Perinatal Parent Infant Mental Health Service (PPIMHS); and the NLFT SPMHS. Services span 13 London boroughs:

- Barking & Dagenham
- Barnet
- Camden
- City of London
- Enfield
- Hackney
- Haringey
- Havering
- Islington
- Newham
- Redbridge
- Tower Hamlets
- Waltham Forest

The aims of the NCEL Perinatal PC include a reduction in inequalities in access to service provision, improved access, alternative admission where appropriate, avoiding delayed discharge, increased service user involvement and improved stakeholder relationships.

The SPMHS are currently commissioned by NHS England via two Integrated Care Boards (ICBs) – North East London (NEL) ICB and North Central London (NCL) ICB, and there will be further delegation of these responsibilities to ICBs in April 2025. The MBU is commissioned by NHS England, via delegation to ELFT as the lead provider within the Collaborative.

These specialist services sit within a network of universal and targeted provision for supporting perinatal mental health including health visiting, midwifery, GPs, voluntary services, Talking Therapies and Community Mental Health teams.

Aims and methodology

This Strategic Health Needs Assessment (SHNA) was led by Anna Freud and co-produced with local professionals and families across the NCEL Perinatal Provider Collaborative (PC) footprint. It was conducted between September and December 2024.

The SHNA explores the following research questions:

1. What is the demographic and health profile of women and birthing people of child-bearing age across NCEL?
2. What is the prevalence of risk factors associated with perinatal mental health (PMH) difficulties across NCEL?
3. Who is giving birth in NCEL, what is the trend in birth rates and what are the outcomes for women, birthing people and babies?
4. What is the demographic and health profile of those admitted into specialist PMH provision, and what is the prevalence of social risk factors in this population?
5. What are service users' and carers' experiences of services for moderate-severe PMH difficulties across NCEL and what does this tell us about how future services should be shaped?

To answer these questions, we drew from the following data sources:

Parent insights

The views and experiences of local women and families are central to understanding the strengths and areas for improvement in service provision. This report brings together a range of previously collected and new data from local parents.

Previous insights gathered from local families with experience of admission to an MBU were analysed. These insights include data shared in the MBU Quality Performance Report for September 2024, feedback from women provided to the Clinical Case Manager in October 2024 and insights from an ELFT consultation with women admitted to an MBU from September 2023.

To further enrich this insight and to increase the diversity of community voices included in this project, we carried out focus groups and 1-1 discussions with local parents. We aimed to hear from local parents and service users from across the three NHS Trusts. A total of 13 people gave feedback via four focus groups and one interview; all were held online, except one in-person group held at the East London MBU.

Of the 13 participants, 12 were female and one was male. Four had experiences of admission to an MBU, and the others were mixed in whether or not they had accessed perinatal mental health support through the NHS. Five were White, two Asian or Asian British, two Black, one of mixed heritage and three preferred not to

say. Five were single, five were in heterosexual relationships and three preferred not to say. Four identified as having a disability. Participants ranged in age from 20 to 47, with a mean average age of 31. Borough of residence was not collected from all participants but for the eight that provided this data, three were from Tower Hamlets, three were from Haringey, one was from Waltham Forest, and one was from Hackney.

The project was steered by an Expert by Experience working group who met three times over the course of the project. The group members were four mothers who had previously either accessed perinatal mental health support, or who recognised that they needed support but were unable to access it. Three were from White heritages and one from mixed heritage. The first meeting focussed on overall feedback on the project and identifying priorities for data collection; the second focussed on developing questions and agendas for focus groups with families and the stakeholder workshops; the third reviewed the findings and recommendations and discussed how to communicate these with the public. The participation work for this project was led by an Anna Freud Participation in Research Officer, with support from an Anna Freud research intern with lived experience of accessing perinatal mental health support.

Professional insights

We held discussions with 28 local professionals from across NCEL PMH service provision to better understand the strengths, challenges and areas for development. Discussions were held online on Teams and lasted between 30 minutes and an hour. This included strategic and clinical leads within the Perinatal PC, service managers and clinical staff within the five SPMHSs and the East London MBU, and one voluntary organisation.

Nationally and locally available data

Data on the demographics of the population of the NCEL boroughs and the prevalence of risk factors was accessed from publicly available datasets provided by the Office for National Statistics (ONS), including Census data (2021), Government department data (via Gov.uk) and Public Health Profiles (Fingertips data). Data on people giving birth was obtained from the NHS Digital Maternity Services Dashboard and Trust-level data on SPMHSs from the NHS England Perinatal Mental Health Dashboard.

Service-level data

SPMHS-level data was collected via each of the five SPMHSs and the East London MBU, including:

- Performance data, such as data on referrals, caseloads, waiting times, length of treatment or duration of stay.
- Demographic data, such as numbers of women living in the most deprived areas and ethnicity and ages of service users.
- Outcome data, such as rates of collection of key outcome measures and paired measures.

Developing recommendations

Two workshops were held with a total of 25 local stakeholders including one local parent, at which participants were asked to sense check and feedback on emerging learning. Recommendations were co-developed with attendees and by the Expert by Experience working group.

Findings

The following two sections present data collected and analysed for the SHNA from across the NCEL footprint.

Section 1 presents qualitative data from local parents and professionals on the strengths and challenges associated with service provision.

Section 2 provides a summary of quantitative data on the need for moderate to severe perinatal mental health services, and the delivery and reach of current service provision. To explore the estimated need for services, we examined the demographic profile of women and birthing people of childbearing age, the prevalence of perinatal mental health risk factors[1] and data on who is giving birth across the thirteen London boroughs. To explore service delivery and reach in each area, we examined the available data including on referrals, wait times, caseloads, duration of treatment and ethnicity.

The full datasets are available in **Appendix A.** In Appendix A, the data is presented in three sections by NHS Trust, and with a fourth section for the Mother and Baby Unit (MBU), which sits within ELFT but serves the wider NCEL footprint.

[1] Data on domestic abuse incidents and crimes are reported publicly at the level of the associated Police Force. As almost all of boroughs in the Perinatal PC footprint are covered by the Metropolitan Police Force, it is not possible to explore differences in the prevalence of domestic abuse between boroughs.

1. Insights from local parents and professionals

Insights on the strengths and challenges in specialist perinatal mental health service provision in NCEL was elicited from local parents and professionals (see the Aims and Methodology section for further detail). The learning is presented here via six themes:

- Types and quality of services available
- Pathways and collaboration between services
- Accessibility of services
- Co-production and participation
- Workforce
- Perinatal Provider Collaborative model

Feedback from local parents is prioritised and signposted by pink text. Feedback from professionals is signposted by green text.

Key findings

Types and quality of services available

Insights from service users and local parents:

- Feedback on MBU provision was mixed. Some women described MBUs as therapeutic environments and others experienced the wards as clinical and harsh. Some wanted more information and communication around medication, and more collaborative care planning. Patients admitted to the East London MBU raised concerns about the quality of food on the MBU and desired greater say in what they eat. [Recommendation 4]
- Some service users highly valued the support they received from their local SPMHS. There was mixed feedback on whether treatment planning felt collaborative.

Insights from professionals:

- Identified areas for service development included inpatient care for women whose babies are removed from their care and women who experience baby loss.
- There is an identified need for an increased focus on babies' development and needs on the East London MBU.
- There are inequities in the availability of the services that can be provided by different SPMHSs, linked to funding and workforce challenges.

[Recommendation 4 and 8]

Pathways and collaboration between services

Insights from service users and local parents:

- There were varied experiences of admission on the MBU and for some, uncertainty around bed availability, timeframes to being admitted and a lack of communication created an additional source of anxiety and distress.

- Several of the MBU patients we heard from described discharge positively, including good engagement from the community SPMHS. Others, who were current in-patients, were concerned about discharge and felt underprepared.

[Recommendation 6]

Insights from professionals:

- There can be delays in the responsiveness of the MBU to referrals from SPMHSs. Referrals received by the MBU can be of poor quality. The Perinatal PC case manager role was seen as valuable for improving cross-agency working.
- Disparities were described in the quality of the working relationship between different SPMHSs and the MBU. The attendance of SPMHSs at ward rounds can be inconsistent and there are challenges with poor internet connection when professionals join via Teams.
- There are challenges with the single point of access policy at the MBU.
- There is appetite to improve collaboration between the MBU and SPMHSs, and acute female inpatient provision.
- Services operating outside of specialist perinatal mental health provision are seen as not routinely prioritising perinatal patients.

[Recommendation 6]

Accessibility of services

Insights from service users and local parents:

- There is limited awareness of perinatal mental health services in the community.
- Stigma plays a significant role in limiting people's access to perinatal mental health services. Parents described a need for services to acknowledge and respond to cultural and social attitudes around help seeking. [Recommendation 1]
- Improving support for fathers and partners was a priority. [Recommendation 3]

Insights from professionals:

- Broadly speaking, SPMHSs and the MBU reported feeling relatively confident in the accessibility of services to diverse ethnic groups. They identified particular ethnic groups living within each service footprint who are not accessing specialist perinatal mental health services [Recommendations 5 and 8]
- LGBTQ+ families do not appear to be accessing specialist services and further data collection is needed. [Recommendations 8 and 9]

Co-production and participation

Insights from professionals:

- ELFT has a well-established and ongoing commitment to perinatal participation work and further prioritisation of this was identified as an area for development in NELFT PPIMHS and NLFT SPMHS.

[Recommendation 7]

Workforce

Insights from service users and local parents:

- Parents identified training needs in the wider workforce working with perinatal women, including on identifying perinatal mental health needs and on how and where to refer on to for additional support. Training for midwives, health visitors and GPs on providing compassionate care and active listening was recommended.

Insights from professionals:

- There are a range of staffing challenges across the Trusts which impede services ability to provide equitable services to families.
- Professionals identified the need for a rolling training programme across NCEL for the SPMHS and MBU workforce.

[Recommendation 2]

Perinatal Provider Collaborative model

Insights from professionals:

- Complex and seemingly fragmented commissioning arrangements can make the task of developing and refining the whole pathway of support more difficult. Commissioning bodies have different funding priorities, which has led to variations in the amount and stability of funding available to SPMHSs.

[Recommendation 6]

1.1 Types and quality of services available

The East London MBU

We collated patients' experiences of being treated on MBUs, including the East London MBU. Some described the ward as a therapeutic environment with supportive staff and a variety of activities that combined therapeutic and holistic treatment. Women valued feeling listened to and felt staff were conscious of and responsive to their needs. Peer support was highlighted as a positive element of care, with one woman commenting, "it will be a good day if [the peer worker] is working."

For others, their experience on an MBU was more challenging. The environment was described as feeling "harsh", "institutional and austere", clinical and at times noisy. Greater preparation for an MBU was felt to be needed, particularly around what the ward would be like. Women felt more baby-focused activities would be beneficial, as well as the opportunity to engage in evening activities, which can be

a peak time for anxiety. Several women commented that bank and night staff needed more training on working in an MBU.

"I am more than my environment, but it does get to you after a while". MBU patient

Medication was flagged as a key issue in discussions. Some women felt pressured into accepting medication and felt they had limited understanding of the side effects. These women wanted more information and communication around medication, including sharing information with family members, to support them to feel comfortable with decision-making around medication. Generally, it was felt care planning should feel more collaborative where possible.

"On the MBU they're just going to medicate you. If that doesn't work, we're going to increase it." MBU patient

Women admitted to the East London MBU described food options as limited, feeling food was heavily processed and there was little cultural consideration. Women also spoke about not receiving meals they had requested. Suggestions included the opportunity for women to cook their own meals and making menus more nutritious to support wellbeing and recovery. One woman reflected that the routine in the MBU around food and drink provision was not reflective of, or adaptable to, a home environment. For example, health and safety restrictions in the kitchen mean that "you can't even learn to make a cup of tea with a baby".

See Recommendation 4

From a **professional perspective**, the East London MBU is widely recognised as delivering high quality and effective support through a range of treatments. Professional feedback identified two areas for further service development. These were care for women whose partners do not give consent for admission to an MBU and meeting babies' needs. In relation to meeting babies' needs, it was felt that there is a need for more nursery nurses on the ward in response to an increase in acuity and the associated need for baby observation. More formalised health visitor input would also help to place a greater focus on the needs of babies. For older babies, there are tensions between babies' need to be mobile around the ward and health and safety restrictions. Finally, there was appetite to consider the relationship of the baby to the ward; mothers, rather than babies, are the patient and babies are seen as 'guests' and currently babies do not have their own patient record.

See Recommendations 4 and 8

SPMHSs

Some local parents described how they highly valued the support provided by their SPMHS. One local parent described trusting their local SPMHS "as much as my own family". Another valued the experience of having someone alongside them during their mental health difficulties; "I needed someone to just listen to me and try to help me figure out or even if there wasn't the solution, just let me get it out. And yeah, they did give me that space."

There was mixed feedback from women around how collaborative treatment planning felt. Some women were satisfied with having their treatment plan decided by professionals and felt the plan was well-explained to them. One woman felt she was not given adequate information on possible treatment options and would have liked to have been offered information from which to make a decision. Conversely, another woman felt overwhelmed by information on available treatments and pressured to make and keep to a decision; she described this as like being given an extensive food menu to choose from only for the waiter to arrive slightly before you are ready to choose.

See Recommendation 2

Professionals described inequity in the availability of the services that can be provided by different SPMHS across NCEL. For example, City & Hackney SPMHS are an example of a well-funded service which is able to offer variety of interventions and treatment. City & Hackney and Newham are the only SPMHSs in the NCEL areas that are currently offering intensive pathways of support, in which women receive intensive support in the community via collaboration between SMPHSs and home treatment teams. The NELFT PPIMHS has a robust parent-infant relationship support offer but experience challenges in delivering a perinatal psychiatric support offer; however, Newham SPMHS is not able to routinely offer support for parent-infant relationships. The NELFT PPIMHS is not able to routinely extend their perinatal psychiatric provision to include women with babies up to 24 months. This was raised as a concern for several local parents:

"Now I've been handed over to the normal community mental health team [because my child is one] I don't feel as supported at all as I was with the perinatal team. I had one meeting and that was it. I haven't heard anything else from them." Local parent

See Recommendation 6

A pressing concern for two SPMHSs is the availability of appropriate estates for service delivery. Newham SPMHS has access to one portacabin with two rooms in which to see their caseload. Assessing women digitally presents challenges, including difficulty in assessing the need for parent-infant support, child safeguarding and risk management, poor internet connections increasing the length of appointments, and concerns about who else might be present in the

house. NLFT SPMHS South team, a sub-team within NLFT offering care to patients in Camden and Islington, experiences challenges with securing adequate and appropriate space in which to deliver face-to-face appointments, and this is felt to have an impact on staff retention.

1.2 Pathways and collaboration between services

See Recommendation 6

Being admitted onto the MBU

Patients described a varied experience of admission on the MBU. For some, there was felt to be "inconsistency and confusion" around admission. Uncertainty around bed availability and timeframes to being admitted to the MBU, and a lack of communication, created an additional source of anxiety and distress. One local parent described how her mental health symptoms became more acute while waiting for support after being assessed, during which time she was admitted to A&E. One patient describes her experience of admission to the East London MBU via A&E below:

"Where am I going to go? What, what is happening? No one knew anything. And it's like because you're not acute, you know, you don't have, like, a cut on your leg or something like physically wrong with you. They kind of ignore you a bit. And yeah, so the experience in itself was quite bad." MBU patient

For others, the process was straightforward and the initial ward 'walk arounds' were identified as helpful in familiarising women with the environment. Women expressed a need for clear explanations and transparency during this time. Having access to advocacy, and the provision of information about the MBU and their rights, improved the experience.

Feedback from professionals indicated that referrals made from the SPMHS to the MBU are not always responded to within the timeframes set out in the National Access and Egress policy, particularly at weekends and out of hours, and responsiveness to referrals was described by some services as inconsistent. This was felt to be more easily managed by teams with an intensive pathway offer but is a particular challenge to women presenting in A&E. Some SPMHSs described the referral process into the MBU as "daunting", while the MBU felt that the quality of referrals received is at times poor and time is taken up by following up with referrers.

The recently established Perinatal PC case manager role was widely seen as a positive step towards improving cross-agency working between the MBU and SPMHSs. There was appetite for a formalised in-reach/outreach service to support referrals in and discharge out of the MBU.

Relationship between SPMHSs and MBU once women are admitted to MBU

Professionals described disparities in the quality of the working relationship between different SPMHSs and the MBU. There was seen to be more effective join up between the ELFT SPMHSs and the MBU, facilitated by existing professional relationships and geographical proximity rather than formal processes. The attendance of SPMHSs at ward rounds was described as "patchy" even for services located close to the MBU and some SPMHS described not receiving invitations to ward rounds for all relevant women. Ward rounds can be attended online; however this can be problematic due to the poor internet connection. This can mean it is difficult to hear what is being said and sometimes staff need to resort to typing.

Out of area MBU placements and the single point of access

The East London MBU operates a single point of access policy in accordance with national policy with the aim of ensuring consistency of support. This requires all MBU referrals for women within the NCEL area to be triaged by the East London MBU, and where required, alternative placement being overseen by the Perinatal PC case manager. Frustration with this approach was expressed by some SPMHSs, particularly when the referrer is aware that the East London MBU is at capacity or responsiveness is delayed. Feedback suggests that some referrers are bypassing the East London MBU and contacting alternative MBUs directly or including other MBUs in referral emails to the East London MBU, which can complicate and lengthen the referral processes. It was also noted that duplicate assessments of women sometimes take place following triage at the East London MBU and the placement of women out of area.

Length of stay and discharge from the MBU

Several of the MBU patients we heard from described discharge positively, including good engagement from the community SPMHS who had attended wards and were felt to be proactive in providing support. Others who were in-patients at the time of interview, were concerned about discharge and felt underprepared. Women described wanting more information about discharge planning, support for financial concerns such as paying bills and receiving benefits, and a network to stay connected to other mums. One idea suggested by a service user was to create an "outside centre for inside patients", which would provide a ready-made network for mums leaving the MBU to stay connected with others when they "graduate to the outside". Face-to-face appointments with services in the community were felt to be preferential to online support, as mothers felt able to open up more in person.

MBU staff report a recent increase in the complexity and severity of women's mental health difficulties. There are reportedly more women on the ward with a long-standing mental illness rather than a perinatal-specific mental illness. Increased acuity can impact on the type of treatment required, engagement with that treatment and the extent to which other services are involved in the care provided, which in turn can impact on length of stay. Reasons for delayed discharge include:

- wait times for parenting assessments due to take place in another borough.

- lack of other support in place for women experiencing difficulties in other aspects of their lives, for example refugees, those with learning disabilities, or those without housing.
- difficulties with women being accepted onto SPMHS's caseloads, for example where SPMHSs are not able to routinely accept women with babies over 12 months.
- safeguarding concerns and challenges in social care provision, meaning that women and babies are required to stay in the MBU longer than is clinically required.
- the length of time for which beds in the MBU are held when women are 'on leave'. =

Perinatal patients on acute inpatient wards

There is appetite within the MBU to improve collaboration between the MBU and SPMHSs, and acute female inpatient provision. It was felt that women who are not able to be placed in the MBU often do not have access to specialist psychological or psychiatric perinatal input and could benefit from greater connectivity between services. Some SPMHSs described not being made aware of women on their caseload being admitted to acute inpatient wards.

An area for service development highlighted by professionals was inpatient care for women whose babies are removed from their care and who experience baby loss. There was felt to be a need for greater consideration of where and how care can be delivered, avoiding the need for women to stay in environments with babies but at the same time receiving specialist perinatal care.

Collaboration between SPMHS and other community services

SPMHSs work with a large variety of local community services and we heard many examples of effective working relationships. The local parents we spoke to described positive experiences of being supported by SMPHS to access or contact other services. One local parent described how their local SPMHS helped them to access holistic support for their whole family:

"I was able to be referred to different people to help with different things. Within the PMH team I had someone who was able to help me get furniture, even though I have a 3-year-old as well and they are trying now to help me get him into nursery, because his nursery closed down." Local parent

Another described frustration at her experience of seeking specialist perinatal mental health support via her GP. She felt there was a lack of communication between services and organisations, which meant that she wasn't contacted by her local SPMHS for three months: "They did call, but by the time they did, I didn't really need it".

However, in light of the capacity and resource challenges many services are currently facing, professionals described challenges associated with being able to discharge women from SPMHSs to lower intensity services. SPMHSs reported that

other services are not able to routinely prioritise perinatal patients. There was also a desire for increased clarity of the eligibility criteria for maternal mental health services and perinatal mental health services.

"It's always a challenge when you're aware that another service is stretched, but at the same time, you really need them to do something. And it's always walking that tightrope of how politely can I say my need is greater than somebody else's." Professional stakeholder.

1.3 Accessibility of services

Limited knowledge of available services and how to access support
A common difficulty described by local parents was not knowing that perinatal mental health services were available. It was felt that services need to be signposted more clearly, at the latest during pregnancy, and not only to mothers but to society as a whole. The way in which services are promoted was also important; for example, one woman described being offered a support class, but the email containing the necessary information went into her 'junk' mail folder.

"They could have sent a reminder or something to my mobile phone". Local parent

See Recommendation 1

Thresholds
Some local parents felt that the thresholds for access to SPMHS are too high, meaning that people whose experiences are less severe are often overlooked. Another woman described feeling she needed to exaggerate her symptoms in order to receive the support she felt she needed.

"I do have the impression that you need to make your symptoms worse than what they are so that the GP will pay attention". Local parent

Several women described being referred to Talking Therapies when they didn't meet the threshold for support from their local SPMHS. They found this support helpful but felt it wasn't well set up for new mums and babies. Another mum paid for private counselling because NHS support wasn't available.

Stigma
Parents and professionals identified stigma as a barrier to people accessing services. Parents described their fear that their children would be removed from their care if they disclosed mental health difficulties to professionals.

"Social class has a part to play in this as well, generally in poorer areas and working class areas, there's a fear factor of professional agencies, you don't want your children to get taken away". Local parent

As such, trusting relationships with those providing support were seen as crucial. One woman described being reassured by her therapist's normalisation of how she was feeling, "anyone would be overwhelmed and anxious if they were in your situation." Community-based, voluntary peer support was seen as an important part of care: "having people that are empathetic or understanding or have experience of going through that same situation, even if it's a voluntary service, people might feel a bit more open to talking to them".

See Recommendation 1

Meeting the needs of ethnically diverse groups

Local parents described a need for services to acknowledge and respond to cultural and social norms around getting help for mental health difficulties. They suggested these cultural norms could be more openly discussed with local communities and their elders. An example was given by a Muslim parent of seeing an anonymous post on Facebook where someone had asked for advice around managing depression. This parent's family members had told them not to respond.

"Sometimes people in [our] lives might be a big gaslighty, so [professionals] being aware of some of those cultural and social norms around getting help […] and acknowledging those, I think would be really helpful". Local parent

In relation to the East London MBU specifically, we heard from one patient that patients who do not speak English fluently appear to receive less therapeutic input, as they were less able to ask for support when needed. Her suggestion was for more interpreters or bilingual staff on the ward. Another woman on the MBU described feeling that Black staff were more dismissive of her than of other patients.

Broadly speaking, staff in SPMHSs and the MBU reported feeling relatively confident in the accessibility of services to diverse ethnic groups, including good access to interpreters and translation services and diverse staff groups. There is a range of work underway to examine and respond to racial and ethnic disparities in access to specialist perinatal mental health care. This includes the exploration of access data by ethnicity in City & Hackney and NELFT, ELFT's participation in a Race and Health Observatory project and a collaboration between Newham SPMHS and local maternity services to explore low engagement in services amongst Black African women. There is ongoing work by NLFT midwifery services to increase access to SPMHS for black women living in areas of social deprivation. The NELFT PPIMHS have been undertaking community outreach work in local mosques with the aim of promoting services and reducing stigma. NLFT partner with a local Jewish charity and discuss the care of shared patients in an MDT meeting.

A number of areas for development to improve the accessibility of services to diverse ethnic groups were identified. In Newham, there is felt to be a need to

improve the accessibility of services to Black African women, and in City & Hackney, the SPMHS wishes to improve accessibility for Afro Caribbean women and orthodox Jews. Tower Hamlets SPMHS identified the need to support South Asian women with engaging in intensive psychological interventions, and MBU staff felt women would benefit from greater access to interpreters outside of ward rounds and treatment.

See Recommendations 1, 5 and 8

Meeting the needs of fathers and partners

Improving support for fathers and partners was felt to be a priority for the local parents to whom we spoke. We heard from and about a number of fathers who had struggled with their mental health during the perinatal period but this was not identified by services and they did not access any help. It was felt that fathers are not routinely included in physical or mental health support provided to women during the perinatal period, and this can leave them feeling isolated.

"I can't tell anyone about my experience of my mental health because I don't wanna lose my job, but I lost my job in the end of it because my mental health got too bad." Local father

It was felt that fathers should be more involved in all the care that women receive during the perinatal period, not just when women are experiencing perinatal mental health difficulties. Participants felt that fathers should be encouraged to attend appointments and support groups provided for mums and that more support should be provided to help fathers bond with their baby. Increasing opportunities for fathers to be involved in a women's care could also support the couple relationship and in turn impact on both parents' ability to cope with parenthood.

"The care is geared towards the mother because she's carrying the baby, then if you're the other parent then […] you don't need to be checked up in that way, so you never need to go in for an appointment. It can feel very like going into an alien world, you go into the hospital to support your Mrs because you don't know what's going on at all. […] Often, I go to the hospital every single time, I just have to sit outside. […] I have to ask afterwards, what's going on. There's been no point at which anyone's asked me if I'm doing okay." Local parent

A variety of initiatives within specialist perinatal provision to further engage fathers and partners in care have been tried. For example, the City & Hackney SPMHS have trialled a 'wellbeing chat' with partners and are working with Family Hubs to create a father friendly borough. There is a partners' group at the MBU, and fathers and partners receive a welcome pack and are offered meetings with key care providers. NLFT SPMHS have developed a wellbeing conversation template on RIO for piloting and have also developed a partners' resource pack, and the Maple Maternal Mental Health Service provides equal access to assessment and therapy for fathers and partners, despite no additional funding allocation.

However, engaging fathers continues to be a challenge in all areas, particularly due to challenges around the provision of out of working hours appointments to facilitate attendance. It was also felt there is a lack of clarity on how to implement expectations for assessing and signposting fathers for support.

See Recommendation 3

Meeting the needs of LGBTQ+ families

Professionals reported that LGBTQ+ families do not appear to be accessing specialist perinatal mental health services. Data on gender identity and sexuality is not routinely collected which makes it difficult to know whether and which people within this diverse community are being supported according to their needs. Lesbian and bisexual women, non-binary people and transmen are at greater risk of mental health difficulties than heterosexual people, and with approximately 2-10% of people identifying at LGB+ across the NCEL Perinatal PC, it is crucial to better understand who is accessing services and how engagement can be improved.

See Recommendations 8 and 9

Social determinants of health

The impact of social determinants of health on the prevalence of mental health difficulties and on people's ability to engage with services was raised by local parents and professionals. Key challenges were poverty and housing difficulties.

"We're not even a third world country but it's almost heading that way …If they want people in good jobs, if they want people to have stable lives, not at crisis where kids are ending up in care and with severe mental health problems […], we need to provide the support for the parents who are having the kids, and you need to do it from pregnancy." Local parent

1.4 Co-production and participation

ELFT has a well-established and ongoing commitment to perinatal participation work, and this has to some degree facilitated the development of the participation arm of the Perinatal PC. Key roles within the Collaborative have been established to boost co-production and community engagement with service provision, including expert by experience leads, a Senior People Participation Lead Perinatal and a Clinical Bed/Case Manager whose role includes responsibilities to gather feedback from women about their services of the MBU. There is now work underway to further develop this work to be more inclusive of women's voices from NELFT and NLFT. There are opportunities for greater connectivity around participation across the Collaborative, with ideas including growing participation work in NELFT via a perinatal peer support worker. There is currently no peer support provision in NLFT.

"We need to get women into these spaces, so you're actually hearing from them, the care that they have had and how they feel failed. So somebody is taking accountability for that and then you can make next steps on how you move forward…." Professional stakeholder

1.5 Workforce

See Recommendation 7

Staffing challenges

Professionals felt that inadequate staffing within the NELFT PPIMHS is impacting on the ability to provide the perinatal psychiatric offer alongside the parent-infant support offer. The number of referrals that can be accepted is limited by this staffing deficit, in particular in relation to consultants. Recruitment was also described as a significant challenge in Newham, particularly in relation to psychology. Psychological input is sourced from external providers, and long waiting lists mean that treatment is slowed down. A consultant perinatal psychologist has been recruited to oversee Psychology in ELFT but Newham were unable to invest in this provision. In Tower Hamlets, there are described gaps in staffing for nursery nurses, peer support workers and family support workers to staff the expansion of the service to include mothers with infants up to 24 months. Finally, NLFT SPMHS have ongoing staffing challenges, with the recent expansion of the team, and a high turnover of staff.

In the MBU, there has been an increase in the use of temporary and bank staff to respond to increased acuity, which is felt to be unsettling for patients. The example was given by a professional of women receiving conflicting advice around baby care. Feedback highlighted a desire to recruit more nursery nurses and to formalise input from health visitors and neonate obstetrics to increase focus on infant development, a process which is now underway. One patient described how staff work such long shifts that they become exhausted and can't provide adequate care.

Wider workforce training needs

See Recommendation 2

Local parents and specialist perinatal mental health staff also identified priorities for workforce development in the wider workforce, for example midwives, GPs and health visitors, whilst also recognising the significant pressure these services are under. It was felt that professionals would benefit from training on identifying perinatal mental health needs and on how and where to refer on to for additional support, including midwifery, health visiting, GPs, crisis support services and A&E. Local parents felt this would prevent the onus being on parents who are struggling to be their own advocates.

"Midwives, doctors and stuff they don't really pick up on how you're feeling. They don't sense if you're upset or struggling with something. People are really good at not telling people. If someone tells you they're fine, they're fine." Local parent

One local parent described how she felt her GP wasn't adequately trained to make an informed decision on whether she required specialist mental health treatment. She requested to be referred to the SPMHS against her GPs advice and was subsequently given a diagnosis by a psychiatrist that contradicted that which was given by the GP. The inability of universal services to recognise need was also identified by other parents and parents spoke about their desire for more continuity of care within these services.

Local parents also recommended training for midwives, health visitors and GPs on providing compassionate care and active listening. They described being told by professionals that they were "wasting time" or that their symptoms were "not severe enough" to warrant more support, which made them less likely to seek help again. We heard that one of the most important aspects of care is not who is providing that care, but feeling like that person is genuinely interested in helping you.

Professionals identified the need for a rolling training programme across NCEL for the SPMHS and MBU workforce. A review of training needs in the specialist perinatal mental health workforce is currently underway. Key training gaps identified in this research were:

- In-depth training on perinatal mental health, for example the Institute of Health Visiting's perinatal mental health champions training
- Compassion Focused Therapy
- Working with diverse community groups
- Trauma-informed care
- Safeguarding thresholds, court proceedings and child protection orders
- Baby care and baby-focused activities.

In relation to the MBU specifically, it was suggested that skilling up social care teams to better understand the role and function of the MBU may prevent inappropriate requests being made, for instance for parenting assessments.

1.6 Perinatal Provider Collaborative model

See Recommendation 6

The Perinatal PC model brings together NHS trusts to work collaboratively at scale with the aim of improving efficiency, sustainability and quality of care. Whilst the aims of the model are widely supported, professionals raised a number of implementation challenges.

The MBU and SPMHSs are commissioned via multiple commissioning bodies. These complex and seemingly fragmented commissioning arrangements can make the task of developing and refining the whole pathway of support more difficult. Commissioning bodies across the area have different funding priorities, which has led to variations in the amount and stability of funding available to SPMHSs. In addition, services have different structures; in NELFT and NLFT, there is a 'hub and spoke' model with one central service across some boroughs, delivered via individual teams, and in ELFT, there are individual services for each borough. These factors can create tensions where there are expectations that services can deliver the same standard or type of service.

Some services and local commissioning structures are well-established, whereas others have recently formed with further changes on the horizon, and this may be impacting on how able individual services are to engage with the aims of the Collaborative.

Finally, professionals described how the Collaborative model creates some tension between service provider NHS Trusts in the partnership in relation to the balance of power within the Collaborative in terms of the power and influence of non-lead providers.

"What can happen is that a decision will be made in one borough with no consideration into how that might impact the services that are in neighbouring boroughs or the MBU." Professional stakeholder

2. A summary of quantitative findings

This section is a summary of quantitative data on the estimated need for moderate to severe perinatal mental health services and on the delivery and reach of services from across the NCEL Perinatal PC footprint. The summary compares data from the three NHS Trusts on the following areas:

1. The demographic profile of women of childbearing age
2. The prevalence of perinatal mental health risk factors
3. Who is giving birth?
4. Delivery and reach of Specialist Perinatal Mental Health Services
5. Mother and Baby Unit provision

In this summary section, we have reported either the most recent data available or the most recent data that allows for meaningful comparisons between Trusts. London averages or England averages are provided as comparators where available.

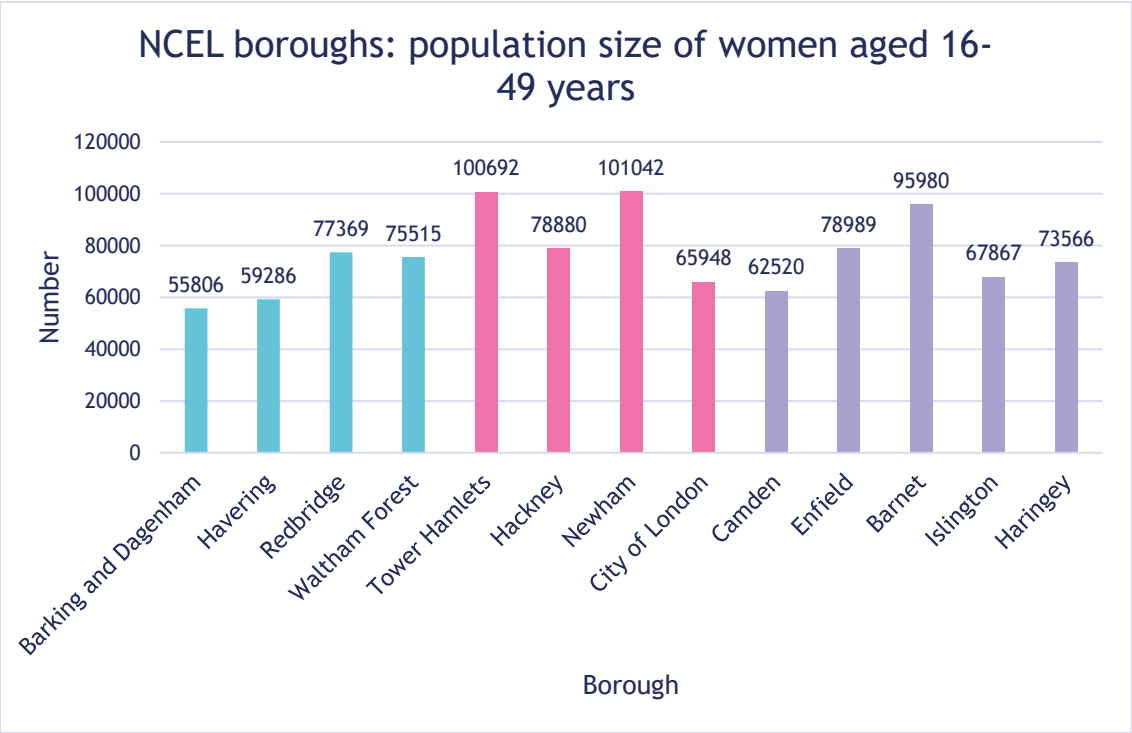
A comprehensive data pack is provided in **Appendix A.** This data is organised by the three NHS Trusts within the NCEL Perinatal PC, and with a separate section for the East London Mother and Baby Unit (MBU), which sits within ELFT but serves the wider NCEL footprint:

- Section 1: Data relating to population need and community specialist perinatal mental health services (SPMHS) in East London NHS Foundation Trust (ELFT)
- Section 2: Data relating to population need and the SPMHS in North East London NHS Foundation Trust (NELFT)
- Section 3: Data relating to population need and the SPMHS in North London NHS Foundation Trust (NLFT)
- Section 4: Data relating to Mother and Baby Unit (MBU) placements and the East London MBU.

Data on race and ethnicity has been analysed and presented via the following broad groups: Asian, Black, Mixed, White, Other. This approach was taken in response to the size and diversity of the population in the NCEL Perinatal PC footprint and variation in the way race and ethnicity data is collected and reported. This approach enables datasets with varying specificity on ethnicity to be aligned and prevents the analysis being too granular to allow the identification of trends and conclusions. Thus, it provides a foundation from which further in-depth analysis can be taken forward. (See **Appendix B** for approaches to grouping ethnicities).

2.1 The demographic profile of women of childbearing age

The number of women of childbearing age (16-49 years old) in the 13 boroughs ranges from 55,806 in Barking & Dagenham to 101,042 in Newham. Across the three NCEL Perinatal PC NHS Trusts, NLFT has the largest number of women of childbearing age (378,922), followed by ELFT (346,561) and NELFT (267,975). The chart below presents the population sizes of women aged 16-49 by borough.

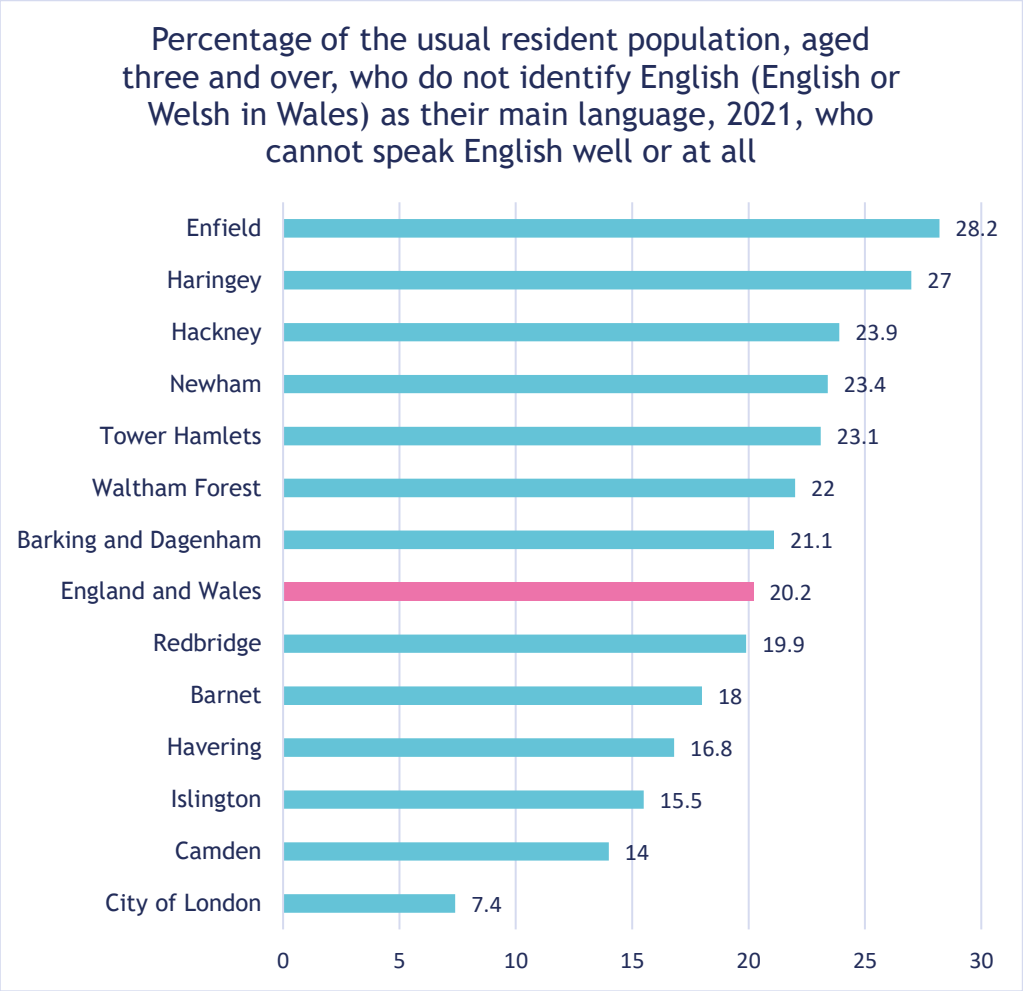


On average in England and Wales, 81.7% of women of childbearing age (aged 16-45 years) are White British, followed by Asian or Asian British women at 9.2% and Black women at 4.2%. There are varying levels of ethnic diversity across and within the three NHS Trusts within NCEL, with significant diversity in some areas:

- ELFT: In Tower Hamlets and Newham, Asian or Asian British women make up the largest ethnic group of women of childbearing age, at 46% and 42% respectively. In Hackney and City of London, the largest ethnic group of women of childbearing age comprises White British women, at 52% and 54% respectively. Newham and Hackney have a notably high proportion of Black women of childbearing age, at 19% and 22% respectively.
- NELFT: In Redbridge, the largest ethnic group of women of childbearing age comprises Asian or Asian British women at 47%, whilst in Havering, 75% are White. Barking & Dagenham have a notably higher proportion of Black women of childbearing age, at 22%.
- NLFT: Approximately 50-60% of women in each of the five boroughs are White. In Barnet and Camden 19% of women (aged 16-45 years) have an

Asian or Asian British ethnicity. In Haringey and Enfield, 18-19% of women of childbearing age are Black or Black British.

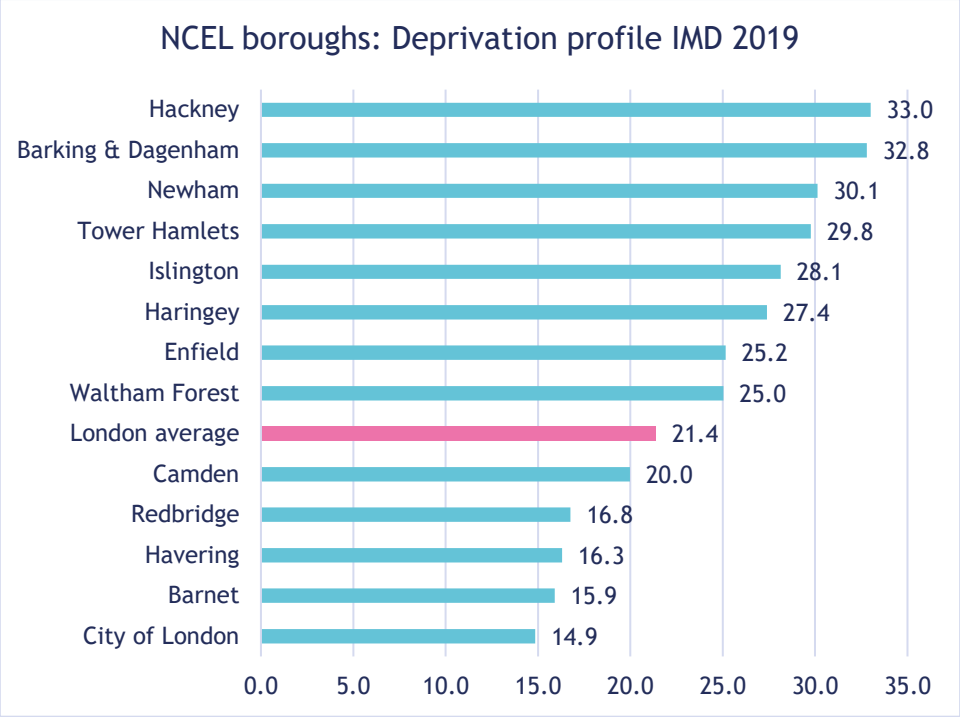
Between 7% and 28% of all residents in the 13 NCEL boroughs who do not identify English as their main language cannot speak English well or at all.



Between 40-54% of residents in 12 of the 13 NCEL boroughs were born overseas, with Newham seeing the highest number. The exception is in Havering, where only 20% of the population was born overseas.

2.2 The prevalence of perinatal mental health risk factors

There is significant deprivation across the NCEL Perinatal PC footprint, with between two and three boroughs in each Trust experiencing higher-than-average levels of deprivation. Hackney and Barking & Dagenham experience the highest levels of deprivation.



The proportions of children who live in relative poverty varies from between 25% in Barnet to 48% in Tower Hamlets, compared to the London average of 40%.

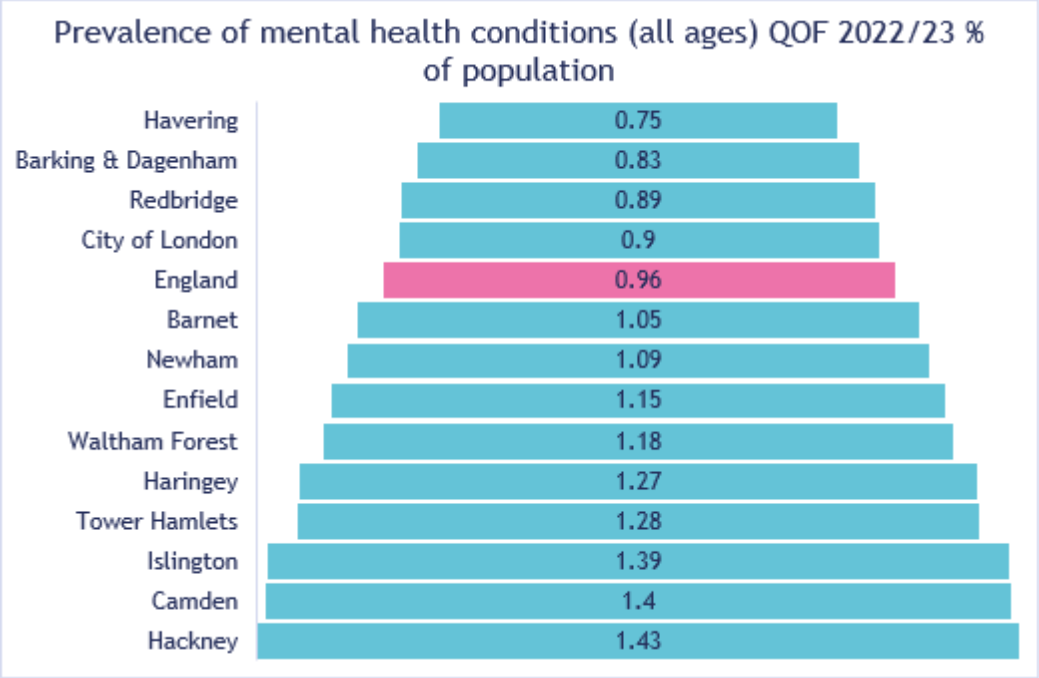
Across the 13 boroughs, 11-19% of single-family households are lone parent households. The majority of boroughs have a higher proportion of lone parent households compared with the London average, with the exception of Tower Hamlets and City of London.

All 13 NCEL boroughs have higher numbers of households in temporary accommodation than the England average, and six (Newham, Redbridge, Hackney, Enfield, Haringey and Tower Hamlets) have higher numbers of households living in temporary accommodation than the London average. Newham has substantially the highest rate, with 51 households per 1,000 living in temporary accommodation, followed by Redbridge at 27 households per 1,000.

The available data suggests that between 2-10% of people living in the NCEL boroughs identify as LGB+.

Nine NCEL boroughs have higher rates of mental health conditions[2] than the England average; Hackney and Camden have the highest rates (1.4%).

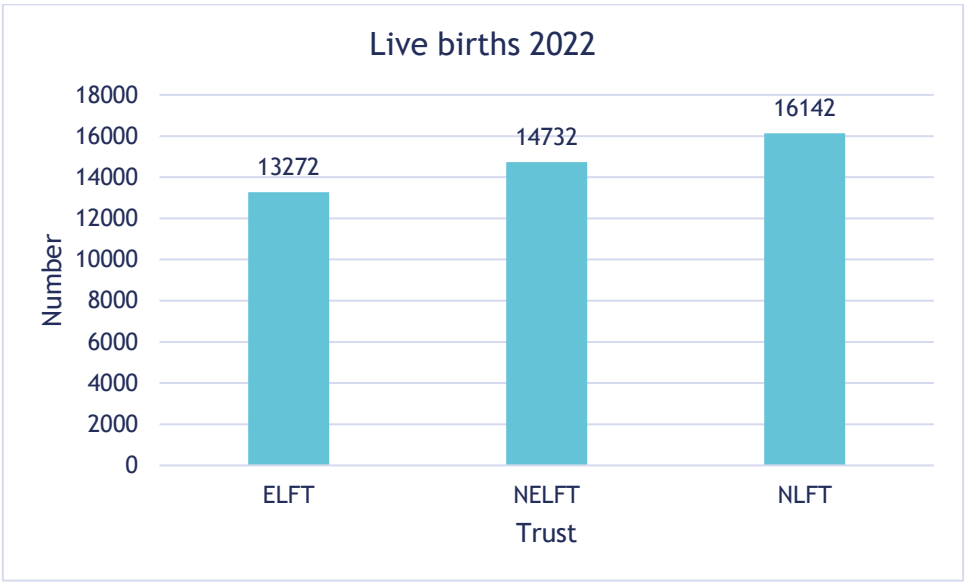
[2] Quality and Outcomes Framework (QOF) prevalence is a measure of how common a condition is in a specific area, based on the percentage of patients with that condition. QOF is a quality framework of indicators for general practice in the NHS.



In summary, the data on the prevalence of perinatal mental health risk factors suggests that there are significant risk factors for perinatal mental health difficulties across the majority of the boroughs, and that there may be a particularly high prevalence of risk for women and birthing people living in Newham, Tower Hamlets, Hackney and Barking & Dagenham.

2.3 Who is giving birth?

In 2022 NLFT had the highest number of live births out of the three NHS Trusts and ELFT the lowest.



The majority of NCEL boroughs have experienced a fall in the rates of under 18 conceptions between June 2018-June 2022. The exceptions are Camden and Waltham Forest which experienced increases between 2020-2022.

Proportionally more women with Asian or Asian British ethnicities gave birth at Barts Health (56%) than the proportion of Asian or Asian British women in the ELFT boroughs (30.8%). Proportionally more women with Asian or Asian British ethnicities gave birth at Barking, Havering and Redbridge University Hospitals (42%) than the proportion of Asian or Asian British women in the NELFT boroughs (26%). The proportions of women giving birth in local hospitals from Asian, Black, Mixed, Other and White ethnicities were similar to the proportion of women living in NLFT boroughs in each ethnic group.

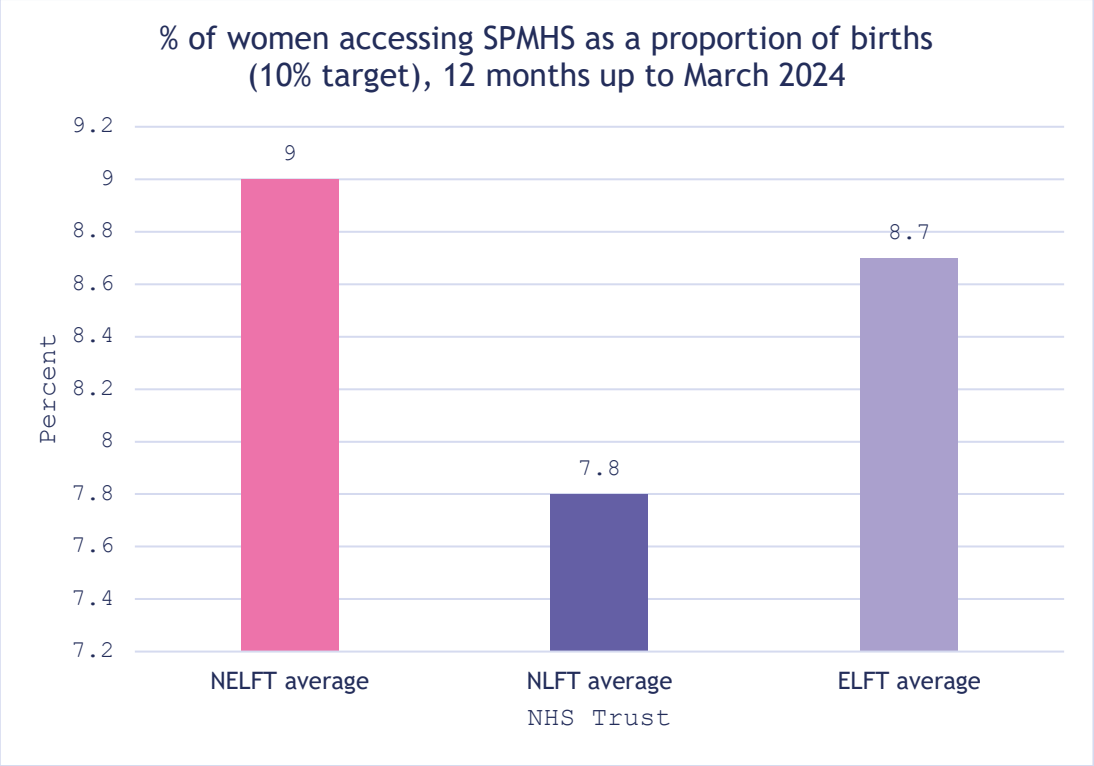
There has been variation in the trend in infant mortality rates in the 13 boroughs between 2021 and 2023; eight boroughs saw increases in their rates and five saw decreases.

2.4 Delivery and reach of Specialist Perinatal Mental Health Services

There are five community Specialist Perinatal Mental Health Services (SPMHSs) operating across the NCEL Perinatal PC footprint. These are:

- Three SPMHSs operating within the four ELFT boroughs: Tower Hamlets SPMHS, Newham SPMHS and Hackney & City SPMHS. Whilst the East London Mother and Baby Unit (MBU) also sits within ELFT boroughs, this data is provided in a following section.
- One SPMHS operating across the four NELFT boroughs, which is known as the Perinatal Parent Infant Mental Health Service (PPIMHS). The PPIMHS includes two teams: Barking & Dagenham and Havering; and Redbridge and Waltham Forest.
- One SPMHS operating across the five NLFT boroughs. The SPMHS includes three teams: Barnet; Enfield and Haringey; and Camden and Islington.

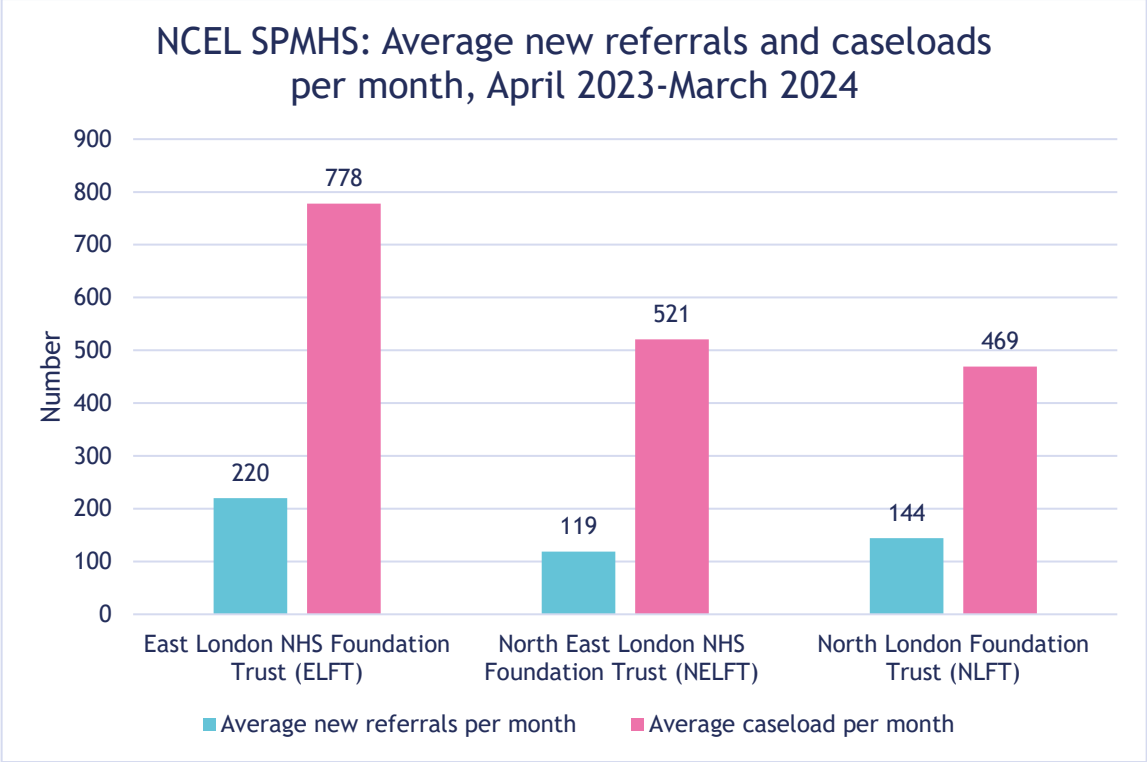
Access rates: At Trust-level, the data indicates that services are working towards meeting the 10% access rate target set by NHS England. In the 12-month period to March 2024 the average access rates of the birthing population to SPMHSs are 8.7% in ELFT, 9% in NELFT and 7.8% in NLFT. At a more localised-level, Havering, Waltham Forest and City & Hackney SPMHSs met the 10% target.



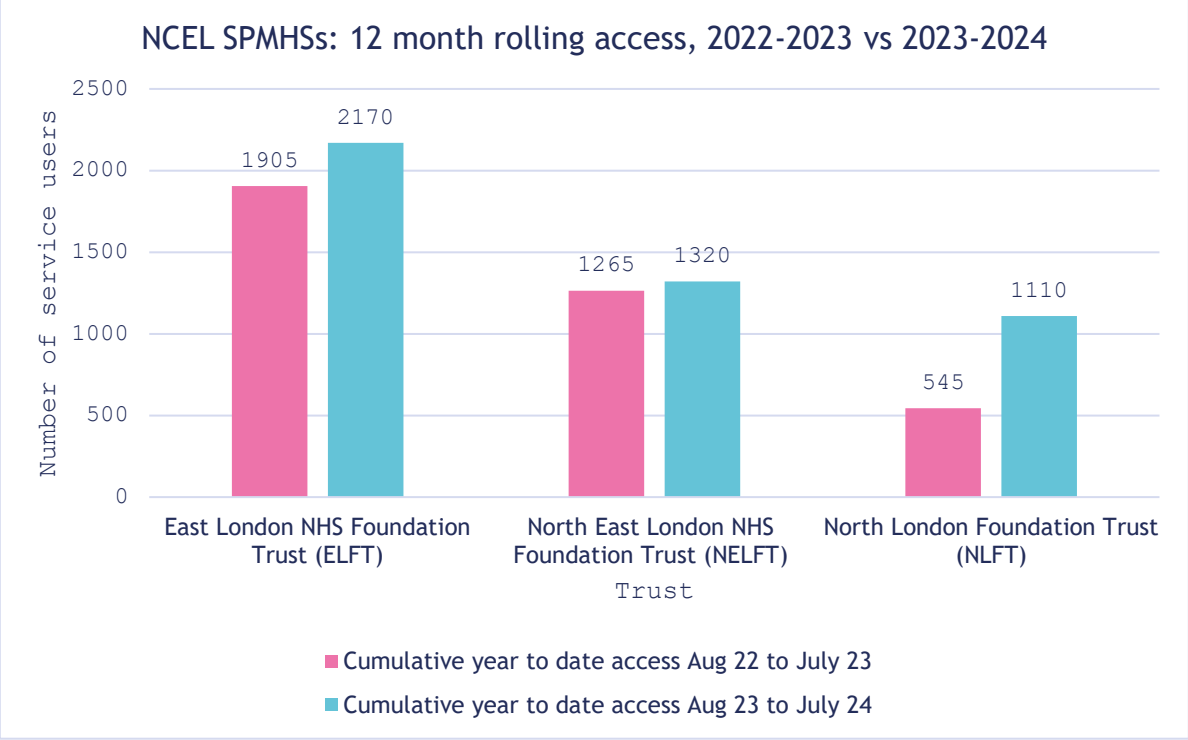
Data reported on the NHS England Perinatal Mental Health Dashboard shows the reach of SPMHSs by Trust on three demographic benchmarks: deprivation, age and ethnicity. The data from July 2024 shows that the reach of the three NHS Trusts was proportionally similar in relation to these benchmarks. Notable differences are: ELFT SPMHSs treated proportionally more women in the most deprived areas (35%) and proportionally more women outside of the 26-39 years range (35%), and NELFT treated proportionally more White British mothers (38%).

		Deprivation benchmark	**Age group benchmark: 26-39 years**	**Ethnicity benchmark: White British**
		% of women on caseload living in the most deprived quintile	% of women on caseload aged 26-39 years	% of women on caseload ethnicity White British
Jul-24	North London Foundation Trust	23.4	71.2	32.7
Jul-24	East London Foundation Trust	34.6	64.9	32.8
Jul-24	North East London Foundation Trust	24.3	71.3	37.8

Caseloads: In the 12-month period between April 2023 and March 2024, ELFT SPMHSs experienced on average the highest number of new referrals each month and held the highest caseload.



Numbers of women accessing services: The number of women accessing support via a SPMHS increased between 2022-23 and 2023-24 in each of the three Trusts, with NLFT experiencing the largest increase with a doubling of service users.



Wait times: The data on wait times for services is reported differently across the three NHS Trusts and some data was not available at the time of reporting. As such, it is not possible to provide a summary of this data. More detail for each Trust and the East London MBU is available in Appendix A.

Ethnicity of service users: The ethnicity data available from SPMHSs was compared with data on the ethnicity of local populations of women of childbearing age, using the following broad groups: Asian, Black, Mixed, White, Other (see the introduction of this section for more information). We found that:

- In the ELFT boroughs, the number of women from Asian, Black, Mixed, Other and White ethnicities seen by the three SPMHSs appears to be approximately proportionate to the population of childbearing women. Notable exceptions to this are:
  - In City & Hackney, where White British women make up 32% of the population and comprise 24% of service users;
  - In Tower Hamlets, where proportionally fewer Black women and White women were supported by SPMHSs; and
  - In Newham, where proportionally fewer Black women were supported.
- In the NELFT boroughs, proportionally more Asian women were supported by the SPMHS compared to the local female population. In Barking & Dagenham and Havering, proportionally fewer white women were supported than their local female populations. In Redbridge and Waltham Forest, proportionally fewer Black and Mixed women were supported.
- In the NLFT boroughs, the proportion of women from White and Asian ethnic groups seen by the service appears to lower than the proportion of women in these ethnic groups in the local populations, whilst proportionally more women with Other ethnicities have been treated.

These findings should be interpreted with caution. The broad race and ethnicity groupings will mask in-group differences in access rates, and in ELFT and NLFT, data on the race and ethnicity of service users was not collected for between 7% and 20% people.

See Recommendation 5

Gender and sexuality of service users: Data is not routinely collected on gender and sexuality.

See Recommendation 9

Staffing: The following table provides an overview of staffing across the Trusts and services at the time of writing, and highlights variations in the structure and provision of local services.

	ELFT			NELFT	NLFT
Job role	**Tower Hamlets SPMHS (WTE)**	**Newham SPMHS (WTE)**	**City & Hackney SPMHS (WTE)**	**PPIMHS (WTE)**	**NLFT SPMHS (WTE)**
Administrator	2.0 (band 4) 0.5 (band 3)	2.2 (band 4)	1.0 (band 4) 1.0 (band 6)	4.0 (band 4)	1.0 (band 6) 1.0 (band 5) 3.0 (band 4) 1.0 (band 3)
Assistant practitioner					2.8 (band 4)
Bilingual support worker	1.0 (band 4)				
Cognitive Behavioural Therapy therapist		0.8 (band 7)			
Clinical lead				4.0 (band 7)	
Consultant psychiatrists	1.2	1.7	1.4	3.0	4.8
Family & systemic psychotherapist			0.6 (band 8a)		
Lead for perinatal mental health	1.0 (band 8c)				
Nursery nurse	1.0 (band 4)	0.9 (band 4)	1.0 (band 4)	4.0 (band 4)	1.0 (band 5) 4.2 (band 4)
Occupational therapist	1.0 (band 6)	0.5 (band 6)	1.0 (band 6) 0.5 (band 7)	2.0 (band 7)	1.7 (band 7) 1.2 (band 6)
Operational lead	1.0 (band 8a)	1.0 (band 8a)	1.0 (band 8b)	1.0 (band 8b)	2.0 (band 8a)
Parent-infant psychotherapist	0.5 (band 8a)		0.5 (band 8a)		
Peer support worker	0.5 (band 3)	0.4 (band 3)	0.5 (band 3)		0.8 (band 4)
People participation lead	0.5 (band 6)				
Perinatal mental health Practitioner		1.0 (band 6)	1.0 (band 6)	4.0 (band 6)	
Perinatal nurse	4 (band 7)	3.5 (band 7)	3.0 (band 7)	8.0 (band 7)	6.4 (band 7) 7.6 (band 6)
Pharmacist	0.6 (band 8a)			1.0 (band 8a)	0.7 (band 8a)
Psychologists	1.0 (band 8a) 1.0 (band 7)	1.0 (band 8a)	0.8 (band 8a) 0.8 (band 7)	1.0 (band 8c) 9.5	1.0 (band 8b) 3.7 (band 8a) 2.9 (band 7)

					2.0 (band 4)
Referral coordinator				1.0 (band 3)	
Social worker	0.6 (band 7)	0.5 (band 6)	0.6 (band 6)		1.0 (band 7) 2.0 (band 6)
Specialist trainee doctor	1.0			1.0	
Speciality doctor		1.0	1.0	1.0	
STP coordinator				1.0 (band 3)	
Team lead				2.0 (band 8a)	
Triage coordinator				1.0 (band 3)	

See Recommendation 4

2.5 Mother and Baby Unit provision

Mother and Baby Unit (MBU) placements: The East London MBU is the sole MBU within the NCEL Perinatal PC footprint. Within this area, women who require MBU admission can either be placed at the East London MBU or within neighbouring MBUs. In October, 75% of women for whom the NCEL Perinatal PC have responsibility were placed in the East London MBU and 25% were placed in alternative MBU provision. The proportion of women admitted to any MBU from ELFT boroughs has been increasing and is higher than admissions from NLFT and NELFT.

Bed occupancy: Since April 2024, the East London MBU has been operating at full capacity.

Admissions: Between April 2023 and March 2024, 35 women (69%) had a planned or booked admission to the East London MBU and 10 women (20%) had an emergency or crisis admission. The majority of women were admitted with a severe (41%) or mild (24%) mental and behavioural disorder associated with a puerperal disorder.

The proportion of women admitted to the East London MBU from ELFT boroughs has increased from an average of 31% between April 2023 and March 2024, to an average of 55% between July and October 2024. This may be the result of a high local prevalence of risk factors for perinatal mental health difficulties and therefore need, coupled with the ELFT SPMHSs seeing the highest number of women across the NCEL Perinatal PC footprint. Conversely, ELFT has the lowest number of women giving birth across the footprint, which might suggest lower demand for MBU treatment. In addition, qualitative feedback suggests closer working relationships between ELFT SPMHSs and the East London MBU, compared to other SPMHSs.

See Recommendation 6

Women admitted under the Mental Health Act (MHA): Of the 51 admissions to the MBU from the Perinatal PC between April and end of October 2024, 24 patients were admitted under the Mental Health Act (MHA) and 27 were 'informal' admissions. 50% (12) of all the women admitted under the MHA reside in NLFT boroughs. The greatest number of informal admissions were for White women, whilst the largest proportion of admissions on both Sections 2 and 3 of the MHA were of Asian and Black patients. Data shows that there has been gradual increase in the number of patients admitted under the MHA over the last three years.

Ethnicity of patients: Between April 2023 and March 2024, a third of the women admitted had a Black or Black British ethnicity. Black or Black British women comprise 11% of those who gave birth in the same time period. This, and the finding above on the proportion of Asian and Black patients admitted to the MBU under the MHA, are concerning findings. They may be related to a number of factors that limit Black and Asian women's access to and engagement with preventative support, including discrimination and racism, cultural attitudes to mental health and getting help, and a lack of knowledge about available services.

Deprivation status of patients: Between April 2023 and March 2024, 69% of women admitted lived in the most deprived areas of the country based upon their IMD score, which compares to 47% of women who gave birth during the same time period.

Previously known to SPMHSs: Between April 2023 and March 2024, 22 women admitted to the MBU were not known to community SPMHS prior to admission. Proportionally more women from White Other ethnic groups who are admitted were not known to community teams prior to admission, whilst proportionally fewer Asian or Asian British women who were admitted were not known.

See Recommendation 6

Length of stay: For the majority of patients, their length of stay at the East London MBU is average compared to other MBUs. However, 18% of patients stayed at the East London MBU for 100 days or more and two women had a length of stay that was 200 days or more.

See Recommendation 6

See Appendix A for the full data packs for each of the three NHS Trusts and the East London MBU.

Recommendations

This section presents the recommendations from the Strategic Health Needs Assessment (SHNA). These nine recommendations were co-developed with local parents and professionals. The recommendations seen as priorities by the service users and local parents who took part in the project are identified.

Recommendations	Role of NCEL Perinatal PC	Lead/Partners
1. **Address limited community awareness of perinatal mental health services and seek to reduce stigma around accessing services.** *Service user priority This could be achieved through action at a universal and targeted level. • At a universal level, approaches to explore include: ○ Promoting SPMHS to all perinatal women and birthing people, via maternity notes and the Bounty pack. ○ Keeping local authority maternity websites up to date with relevant information about PMH services. ○ Promoting SPMHS via Family Hubs or via noticeboards in GP surgeries, and in midwifery and health visiting clinics. ○ Ensuring all SPMHSs are accessible via a self-referral pathway. ○ Promoting SPMHSs to the general population and providing a positive portrayal of outcomes for women and families, for example via advertising on the Tube or through household bills, so that these services become more normalised. • At a targeted level, outreach work with voluntary community organisations could reduce stigma and increase awareness of local services. Improved data collection would mean services are better equipped to identify specific communities to target. The co-production of these approaches with local communities is critical (see Recommendation 7).	Influence and contribute	Integrated Care Boards (ICBs), Specialist Perinatal Mental Health Services (SPMHSs), Voluntary and Community Sector (VCS), Working Together Group (WTG)

2. Upskill the specialist and wider workforce in perinatal mental health difficulties. *Service user priority This might include: • Training for the specialist workforce which includes in-depth information on perinatal mental health and parent-infant relationships, support on working with diverse communities and unconscious bias, trauma-informed care, and working with fathers and partners. It could also include developing the confidence of staff to provide more person-centred care that is responsive to the individual needs and preferences of service users. The training could be provided face-to-face to continue to develop relationships across the Perinatal PC. • A bespoke training package for MBU staff which includes training on court proceedings, child protection orders and baby care. • Supporting the upskilling of the wider workforce, including GPs, midwives and health visitors around the identification of perinatal mental health difficulties, providing compassionate care, having challenging conversations around more severe mental health difficulties and appropriate signposting and referral pathways. This might be achieved through the provision of training, supervision, outreach work or perinatal mental health champions across key services.	Lead and deliver	Training offer development task and finish group, Clinical Leads and Perinatal Champions
3. Develop approaches to engaging fathers and partners through collaboration and sharing of learning across the Perinatal PC. *Service user priority This might include a fathers' and partners' working group, Community of Practice or similar model through which services have the opportunity to come together to share their experiences and learning to date, to research models of good practice and to plan localised action. Any service development should include local fathers and partners.	Influence and contribute	Partner Trusts, ICBs, VCS, NCEL Clinical Quality Stakeholder Group, Perinatal Clinical Networks
4. Review and prioritise areas for development in service delivery with a focus on reducing inequity and develop action plans.	Influence and contribute	ICBs, Maternal Mental Health

Identified areas for further development in service delivery were as follows: **East London MBU -** • Improving care for babies, for example through formalising health visitor input on the ward, improving data collection on outcomes relating to babies, and considering ways to increase the space available to babies for crawling and walking, like linking with local play spaces like Family Hubs. • Improving access to high quality and suitable food [*service user priority] • Facilitating a more collaborative approach to care planning, including improved information sharing and communication around medication [*service user priority] **SPMHSs -** • Addressing the inequity in the types of services available within different SPMHSs including the variety of interventions and treatment, intensive pathways of support, parent-infant relationship support offers and the provision up to 24 months postnatal. **Other services -** • Inpatient care for women whose babies are removed from their care and for women whose babies have died. • The provision of support for women whose partners do not consent to their admission to the MBU.	Deliver	Services, Partner Trusts, WTG, social care
5. Carry out targeted outreach work to engage with specific ethnic groups. It is highly likely that there are particular ethnic groups living within each service footprint who are not accessing specialist perinatal mental health services. There is ongoing work to better understand who those people are and how to support them to engage in services when they need them.	Influence and contribute	ICBs, Partner Trusts, SPMHSs, WTG

Further actions might include: • Facilitating the comprehensive collection of ethnicity data from service users, including on country of birth, religion and languages spoken. • In-depth analysis of data, combined with local practice expertise, to determine specific ethnic groups not accessing services in each borough. • Designing and conducting outreach work with specific communities, developing the approach with community representatives. • Sharing learning across the Perinatal PC.		
6. Improve pathways and collaboration between services. This might include: • Facilitating an equitable and accessible referral and admissions pathway for the East London MBU through a focus on improving referral response times, developing resources for referrers on submitting a quality referral, and through further exploration of the recent pattern of an increase in admissions from ELFT boroughs. • Considering the development of an MBU in-reach, out-reach model to reduce length of stay, improve patient experience and find alternatives to admission if appropriate. Consider the learning from the implementation of the intensive pathways in City & Hackney and Newham, with a view to implementing robust approaches in other areas of the Perinatal PC footprint (keeping in mind the importance of adapting models to local need). • Prioritising relationship-building across specialist services in the Perinatal PC. A key mechanism for improving the efficiency and effectiveness of service pathways, improving patient experience and reducing length of stay in the MBU is likely to lie in the relationships between services. Nurturing trusting professional relationships between services requires sustained effort, particularly due to ongoing changes in the structure of service provision and staff turnover. Actions to support this might include:	Lead & deliver	MBU team referrers (SPMHSs, General Practice, health visiting), London MBUs and MBUs in Natural Clinical Flow) MBU staff, Community Perinatal services, Home Treatment Teams All stakeholders

○ Developing a shared awareness of key staff members, roles and responsibilities, service offers and current service pressures through maintaining and sharing up to date service information. ○ Maintaining engagement with the Perinatal PC at all levels of service including strategic. ○ Providing opportunities to meet face-to-face. ○ Facilitating an open dialogue between service provider NHS Trusts to understand and address any ongoing concerns about power imbalance and inequity in the Perinatal PC.		
7. Develop capacity for co-production in specialist perinatal mental health services. This might include: • A dedicated perinatal peer support role in each Trust, working closely with the Perinatal PC Senior Participation Lead. The aim of these roles would be to develop community relationships and ensure the inclusion of parent and service user voice in service design and development. Securing investment for increased participation in NELFT and NLFT perinatal mental health services could be facilitated by demonstrating the effectiveness of service user voice in improving outcomes. • Training to build professionals understanding, confidence and competence in co-production. • Developing a Perinatal Participation Charter, which sets out core values and aspirations. • Greater peer support capacity within services.	Influence and contribute	Partner Trusts, WTG
8. Strengthening data to inform service provision. Access to reliable data helps to identify health inequalities and enables service improvement. A variety of data is being captured and recorded by specialist services and some data is reported routinely to commissioners. However, the quality of the data is variable. Further developments might include:	Influence and contribute	ICBs, Partner Trusts, Perinatal Improvement Network

• Ensuring the routine collection and collation of data on women's ethnicity, ages, IMD scores and outcome measure scores across all services and for all service users.
• Exploring ways to capture, collate and analyse additional data from service users, including:
  ○ Social context or risk factors of service users, such as employment and housing status, country of birth, previous mental health conditions, involvement with social services and family structure.
  ○ Gender identity and sexuality.
  ○ Infant outcomes for babies on the MBU.
  ○ Data on perinatal women on female acute wards.
• Developing data collection frameworks based on key areas of interest, for example to answer key questions such as:
  ○ How is the duration of treatment in services, or Length of Stay (LOS) for MBU settings, related to service users' social risk factors, presenting needs, ethnicity or other characteristics?
  ○ How is type of admission to the MBU - informal or formal – related to service users characteristics and experience of risk factors?
  ○ What is the relationship between whether MBU patients are known or not known to community SPMHS services, and service users' characteristics and experience of risk factors?
  ○ Why are more Black women admitted to the MBU?
  ○ What can further analysis of ethnicity data tell us about specific ethnic groups not accessing services within boroughs?		

9. Conduct a deep dive into the accessibility of services to LGBTQ+ birthing people and families. Between 2-10% of people living in the Perinatal PC boroughs identify as LGBTQ+ but there is a very limited understanding of whether people from this diverse community are	Influence and contribute	Perinatal Improvement Network, WTG

accessing services. A deep dive into the accessibility of services to the LGBTQ+ community might include: • Hearing the perspectives of local LGBTQ+ families through participation work and the development of relationships with local/national voluntary organisations. • Improving data collection on sexuality and gender identity. • Developing a Perinatal PC-wide approach to ensuring services are accessible and welcoming to this community (for example, agreeing on language and images for promotional materials, names of services) in collaboration with local LGBTQ+ families.		

References

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