Shropshire Council

Children and Young People Needs Assessment

Chapter 2: Maternity (Pregnancy and birth)

May 2026

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Introduction

The Children and Young People JSNA provides a detailed understanding of the needs of children, young people and families in Shropshire to inform the direction and development of local services, with a view to reducing health inequalities through identification, prevention and early intervention.

Due to the vast scope of this product, Shropshire's Children and Young people JSNA is structured as a 'JSNA pack', with individual chapters for each stage of the life course:

Core JSNA chapters

1. Population and context for children and young people
2. Maternity (pregnancy & birth)
3. Early Years (0-4 years)
4. School aged children (5-11 and 11-16 years)
5. Young people (16-19 years)

This chapter presents an overview of the health and wellbeing of maternity and babies across Shropshire. Other chapters are referenced throughout to refer to for certain insights and further information.

Pregnancy is a life-changing event and can have both physical and mental effects on the mother and being healthy during pregnancy is vital to support the baby's growth, prepare the body for the birth and reduce risks of complications to mother and baby. The period between conception and the age of 5 is recognized as having a significant influence on a person's life. The environment a baby experiences whilst in the womb and the first 2 years of life are particularly critical for the child's cognitive, emotional and physical development, likewise, the health and mental health of parents at this time is also critical to family health and wellbeing.

Objectives

Given the broad range of needs and services for pregnant women and new-borns, this report is not an in-depth review of any one specific service but instead aims to provide an overview.

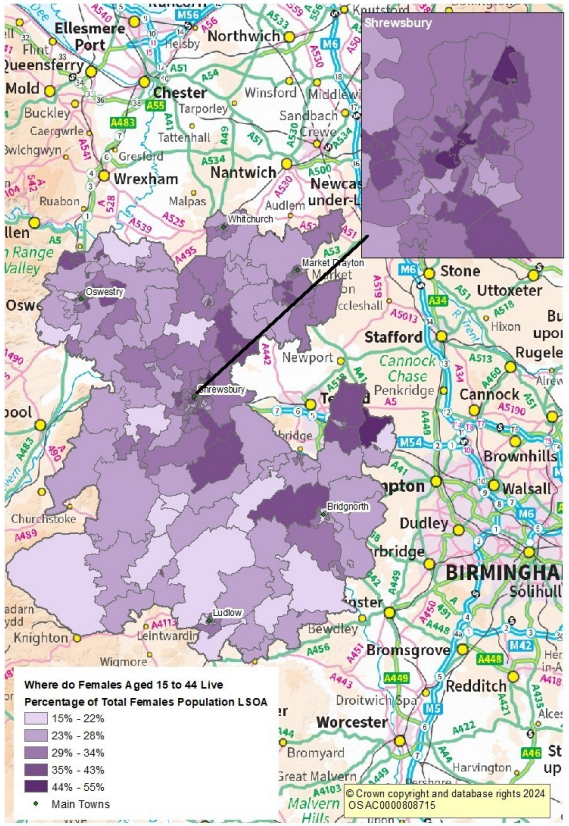
The objectives of this chapter of the Children and Young People's needs assessment therefore are to include the following:

- To describe the population profile of women of child-bearing age - please also see the Population and Context chapter
- To identify risk factors that impact on maternal, infant and child health outcomes - please also see the Population and Context chapter
- To provide an overview of the wider determinants of health and their impact on the pregnant women and new-borns- please also see the Population and Context chapter
- To identify relevant national guidance and local policy in relation to pregnant women and babies
- To provide an overview of the health and wellbeing of pregnant women and new-borns

- To provide an overview of current service provision and assessment of outcomes including gaps in relation to domains impacting on pregnant women and new-borns outcomes; physical, psychosocial and emotional, cognitive and language development
- To identify vulnerable, and/or at-risk groups
- To identify gaps, barriers, and unmet needs in current service provision
- To provide evidence-based recommendations to ensure that the needs of pregnant women and new-borns are met in Shropshire

Executive summary

Where do Females Aged 15 to 44 Live? Shropshire



50,366
Females in Shropshire aged 15 to 44 years (2023) a 2.2% fall from 2011

(England 6.4% increase since 2011)

30.2%
of all Females in Shropshire are aged 15-44 years (15.3% of the total population Male and Female combined)

(England 38.4% of the total female population)

2,406 live births Shropshire (2024)

47.8 General Fertility Rate Shropshire (2023) England 49.4

3.3 Under 18s birth rate per 1,000 births Shropshire (2024)

(England 3.5)

15.7% Under 18s Conception Rate per 1,000 (2022)

(England 13.9%)

22.4% Deliveries to women aged 35 years or above (2023/24)

England (24.7%)

7.1% of expectant mothers were smoking at time of delivery in Shropshire (2024/25) (England 6.1%)

18.4% of expectant mothers were smoking in early pregnancy (2023/24) (England 13.6%)

24.1% of pregnant women were obese in early pregnancy (2018/19) (England 22.1%)

58.6% of expectant mothers had early access to maternity care (2023/24) (England 63.5%)

2.0% of term babies had a low birth rate (2024) (England 3.0%)

41.4% of deliveries were by Caesarean (2023/24) (England 40.9%)

70.2 of babies per 1,000 live births, were born premature (before 37 week's gestation (2020 – 22) (England 77.0%)

2.7 per 1,000 births were stillborn (2022-24) (England 3.9)

81.7% of babies first feed is breastmilk (2023/24) (England 71.9%)

14.2 Multiple Births per 1,000 births (2023) (England 14.5)

Doing well

1. Premature births (less than 37 weeks gestation) - has been significantly below England for the last 4 years and is the lowest in the West Midlands region

2. Low birth weight of term babies – has been significantly below England for 4 out of the last 5 years and is the second lowest in the West Midlands region

3. Low birth weight of all babies - has been below England since 2010 and has been significantly below England in the most recent year and is the lowest in the West Midlands region

4. Baby's first feed breastmilk – has been significantly above England for the last 5 years since the definition of this was altered and is the highest in the West Midlands region

Areas of need (below the national average)

1. Early access to maternity care – Shropshire's performance is significantly lower than the national average and the West Midlands region.

2. Folic acid supplements taken before pregnancy – Shropshire's performance is significantly lower than the national average and has been for the previous 3 years, although there are concerns about the data quality issues affecting the numbers recorded.

3. Smoking in early pregnancy - Shropshire's rates are significantly higher than both England and the West Midlands and is second highest in the West Midlands region, although there are concerns over the data quality for this indicator.

4. Admissions of babies under 14 days. There seems to be a large data quality issue with this indicator as the Shrewsbury and Telford NHS Hospital trust did not submit complete HES maternity data for the financial year ending 2023

5. Emergency admissions for gastroenteritis (0-4 years) - Shropshire's rate of emergency admissions is significantly higher than England and has been since 2012-13, apart from the year of the pandemic 2020/21 and is the seventh highest in the region.

Data caveat: the data period covered in this report coincides with the COVID-19 pandemic and national lockdowns (March 2020 onwards), therefore data may not be a true representation of the service's performance due to the substantial impact on service delivery. For mandated service delivery, virtual contacts were counted as valid for all data for 2020 to 2021 during the period of the pandemic response.

Policy and Guidance

Best Start Family Hubs and Healthy Babies

Best Start Family Hubs are a programme that will be rolled out across the country as part of the Best Start in Life strategy where the government will be spending £1.5billion over the next three years to expand family services, make early education and childcare more accessible and affordable, and improve quality across the early years system. The project is jointly funded by the Department for Education and the Department of Health and Social Care. This investment will help meet the Plan for Change ambition to ensure that a record 75% of children aged 5 achieve a Good Level of Development (GLD) by 2028, reinforcing our commitment to early intervention and boosting long-term outcomes

What are Best Start Family Hubs?

These are local hubs where families can access a range of services all in one place – from pregnancy, through the early years and beyond. The hubs will provide free classes, events and activities to help children before they start school, or to help provide financial or housing advice, and will either directly provide these services or signpost to the right local support. These have been introduced because many parents have said they find it difficult to know where to go for help and because services can feel disconnected and hard to navigate, particularly if their child has additional needs, and some families can't access help at all. Many children's centres have closed or cut back on services, whilst health services have faced new pressures such as fewer health visitors and lower vaccination rates. Research has shown that early support can make a real difference – children who had access to Sure Start centres were more likely to achieve better GCSE results and had improved health outcomes.

What services will be available at the hubs?

Services will vary depending on local needs, but they could involve:

- Stay and play sessions, where you and your child can meet other families
- Parenting advice and courses to boost confidence
- Support with your child's language and emotional development
- Health services and advice
- Help with managing children's behaviour and emotional needs
- Guidance for creating a positive home learning environment
- A trained professional to help navigate services and connect with local early years settings and health services
- A professional trained to support children with additional needs who can help to identify children who may need extra support before starting school; who can help connect parents with local early years settings and health services; who can train family support staff to spot early signs a child might need extra help; provide guidance for navigating the complex system
- A best start digital service is also being created to help with these things for those parents who can't get to a hub

Those Best Start Family Hubs that are delivering Health Babies Services will also be supporting:

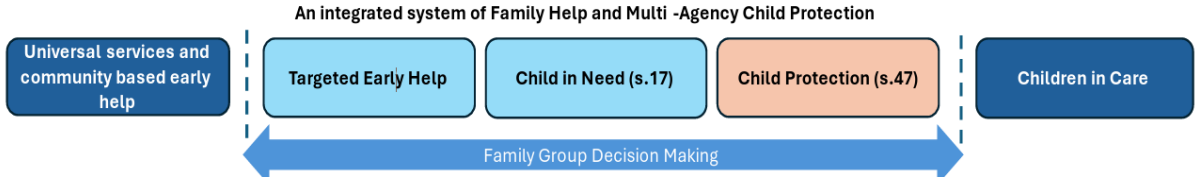
- perinatal mental health
- parent-infant relationships
- infant feeding

The Families First Partnership

The government has set out that it wants to ensure that every child is kept safe so that everyone, regardless of their background or where they live across the country, has the opportunity to succeed. Keeping children safe from multiple forms of abuse and harm and tackling child poverty is the foundation of giving every child the best start in life, ensuring they can achieve and thrive as they grow up. Because of this aim, they are rolling out the Families First Partnership programme – backed by over £500 million of funding in financial year 25/26, through the Local Government Finance Settlement.

All families need support, whether from family or volunteers, private funded services (such as in-home childcare support or paid for therapeutic support) or publicly funded family support or social work. Families have diverse needs and circumstances. The aim of the Families First Partnership (FFP) programme is to transform the whole system of help, support and protection to ensure that every family can access the right help and support when they need it, with strong emphasis on early intervention to prevent crisis. For safeguarding partners to be effective this means considering how different organisations work together to address the needs of children of all ages and whole family approach means to understand the needs of adults in the household too and it is important that local areas consider the diverse backgrounds of families. This transformation should mean that families will know where to go to access help, rather than them feeling like they don't know where to go or are being handed over to different teams.

Vision for a reformed system



The FFP programme will support safeguarding partners to bring together targeted early help, child in need and multi-agency child protection into a seamless system of help, support and protection, which includes services and workforces such as family support workers, social workers and other specialist qualified practitioners.

Health and Social Care Act 2012

The Health and Social Care Act 2012 sets out local authorities' statutory responsibility for commissioning public health services for children and young people aged 0 to 19 years.

Public health services commissioned by local authorities form part of the 'whole system' of support for children and young peoples' health and wellbeing. Local authorities are well placed to ensure integrated commissioning and delivery with a wide range of stakeholders who provide support for physical and mental health and wellbeing, including the NHS and the voluntary and community sector, schools and colleges[1].

The core public health offer

All families with babies are to be offered 5 mandated health visitor reviews before their child reaches 2 and a half years old. The early years reviews are offered to all families. However,

[1] Health and Social Care Act 2012

this is not the extent of the health visiting service offer for families who may also require additional support from the health visiting team, for example feeding, child development, physical or mental health support.

The only mandated elements of provision for 5-19 services is the national child measurement programme at reception and year 6. However, there are opportunities to develop a framework of reviews based on evidence, intelligence, professional judgement and service user voice which provides opportunities to review health and wellbeing needs, support behaviour change and influence outcomes. This presents opportunities for bringing together a robust approach for improving outcomes for children and young people across both health and local authority led services for children and young people aged 0 to 19.

The core public health offer for all children includes:[2].

- child health surveillance (including infant physical examination) and development reviews
- child health protection and screening
- information, advice and support for children, young people and families or carers
- early intervention and targeted support for families with additional needs
- health promotion and prevention by the multi-disciplinary team
- defined support in early years and education settings for children with additional and
- complex health needs
- additional or targeted public health nursing support, for example, support for children in care, young carers, or children of military families

Healthy Child Programme

The healthy child programme is the national delivery model for public health nursing services for those aged 0 to 19 (or up to the age of 25 for care leavers and those with special educational needs and/or disabilities (SEND)) in England. The programme is led by qualified specialist community public health nurses (SCPHNs) and is structured around 2 age-based phases:

- pregnancy and the early years (ages 0 to 5) delivered by health visiting teams
- the school years (ages 5 to 19) delivered by school nursing teams

Each phase reflects the specific developmental priorities of that age group and draws on the professional expertise of qualified staff to ensure a continuous, preventative public health offer from pregnancy through to young adulthood.

The core principle of the healthy child programme is that all babies, children and young people - no matter where they live or their circumstances - should have the opportunity to achieve the best possible health outcomes. This is enabled through high-quality evidence-based 0 to 19 public health nursing services, which are delivered by suitably qualified and competent staff in ways that are proportionate to individual needs, culturally sensitive, and responsive to family context and lived experience.

The healthy child programme is a powerful tool for tackling health inequalities. It is delivered through 4 levels of service:

- community
- universal
- targeted
- specialist

[2] Best Start in life and beyond: healthy child programme 0 to 19

The high-impact areas:

- help services identify population needs and align resources
- ensure that support is tailored, equitable and responsive to local context
- enable practitioners to focus delivery where it can have the greatest impact
- ensure that babies, children, young people and families receive the right support at the right time

This approach provides a foundation for predicting risk and preventing problems, including:

- the early identification of safeguarding concerns
- timely responses to protect babies, children and young people

The universal reach of the healthy child programme provides an invaluable opportunity from early in a child's life to identify families that may need additional support and children who are at risk of poor outcomes.

The healthy child programme provides a framework to support collaborative work and more integrated delivery. It aims to:

- help parents, carers or guardians develop and sustain a strong bond with children
- support parents, carers or guardians in keeping children healthy and safe and reaching their full potential
- protect children from serious disease, through screening and immunisation
- reduce childhood obesity by promoting healthy eating and physical activity
- promote oral health
- support resilience and positive maternal and family mental health
- support the development of healthy relationships and good sexual and reproductive health
- identify health and wellbeing issues early, so support and early interventions can be provided in a timely manner
- make sure children are prepared for and supported in all childcare, early years and education settings and are especially supported to be 'ready to learn at 2 and ready for school by 5

Being ready for school is assessed as every child reaching a level of development which enables them to:

- communicate their needs and have good vocabulary
- become independent in eating, getting dressed and going to the toilet
- take turns, sit still and listen and play
- socialise with peers, form friendships and separate from parents
- have good physical health, including dental health
- be well nourished and within the healthy weight for height range
- have protection against vaccine-preventable infectious diseases, having received all childhood immunisations

It also involves:

- continued support through school age years to help every child to thrive and gain maximum benefit from education, driving high educational achievement
- identifying and helping children, young people and families with problems that might affect their chances later in life, including building resilience to cope with the pressures of life

The Healthy Child Programme aims to bring together health, education and other key partners to deliver an effective programme for prevention and support. Whilst recognising the contribution of other partners, there will be some elements which require clinical

expertise and knowledge that can only be provided through services led and provided by the public health nursing workforce, for example, health visiting and school nursing teams [3].

Shropshire Council recognises that giving every child the Best Start in Life is imperative to reducing inequalities across the life course.

Healthy Child Programme: health visiting (ages 0 to 5)

Health visiting provides a unique universal service, beginning in the antenatal period, that forms the foundation for safe, trusting and respectful relationships with families. Early contacts - specifically the antenatal, new birth and 6-to-8-week health and development reviews - are best delivered in the home by a health visitor. These visits:

- support continuity of care
- offer essential insight into family circumstances and the home environment
- enable early identification of risks to inform safeguarding practice

Home visits enable health visitors to gain a fuller understanding of the family's living conditions and dynamics, which are central to a robust assessment of health needs. Certain indicators of risk may not be apparent in clinical or community settings, such as:

- environmental neglect
- domestic abuse
- unsafe sleeping arrangements

While the 12-month and 2-to-2-and-a-half-year health and development reviews may be delivered flexibly in other suitable venues, such as Best Start Family Hubs, neighbourhood clinics or community settings, this flexibility should be based on family needs and preferences - not service convenience.
This flexibility helps ensure services remain accessible, inclusive and tailored to individual needs. Early contact enables practitioners to build on family strengths, promote resilience and achieve optimal child development. This reinforces the preventative, relationship-based foundation of the healthy child programme.
Named health visitors should deliver all 5 statutory health and development reviews at specified stages to support continuity of care and relationship building. In certain circumstances, a health visitor may delegate a review to a suitably qualified health professional or nursery nurse, provided they are supervised and the health visitor maintains overall accountability.

The following components ensure a sustainable and evidence-informed approach to delivering the healthy child programme. The components have been shaped by extensive stakeholder engagement around meeting the needs of babies, children and families:

- Leadership and workforce
- Commissioning and system alignment
- Integrated working
- Core offer and tailored support
- Emotional wellbeing and communication
- Public health and health promotion
- Family and community focus
- Safeguarding and early intervention

Services within the healthy child programme should be offered across 4 levels of support, community, universal, targeted and specialist.

[3] Best Start in life and beyond: healthy child programme 0 to 19

Community level

At the community level, practitioners contribute to public health by promoting healthy environments and reducing health inequalities through population-wide approaches. This includes:

- raising awareness of crucial health and safety messages
- strengthening community assets through collaboration with local partners
- supporting relational wellbeing - that is, helping families build strong, emotionally attuned relationships that support children's development and resilience. This involves:
    - promoting secure attachments
    - responsive caregiving
    - positive interactions within families and communities
- encouraging a 'Think Family' approach, valuing the relationships around the child and recognising the role of caregivers, families and networks in shaping early development

Universal level

At the universal level, practitioners deliver the core healthy child programme offer through 5 health and development reviews, which must be offered at 5 specified stages. These reviews are offered to all families with children of the eligible age and aim to:

- ensure consistent access
- build trusting relationships
- support early identification of need
- promote equity

Universal reach aims to ensure all families - including those who may face barriers to access - are supported to engage with services at major developmental points.
A plain list of the 5 statutory health and development reviews is provided below:

- antenatal review
- new birth review
- 6-to-8-week review
- 12-month review
- 2-to-2-and-a-half-year review

Targeted level

At the targeted level, practitioners deliver additional support based on an assessment identifying specific needs. These interventions are offered in addition to the 5 statutory universal health and development reviews that must be offered, and aim to:

- reduce escalation of concerns
- build resilience
- empower families through strengths-based and trauma-informed approaches

Targeted support can be structured in 2 ways:

- **Targeted selective support**

Targeted selective support is offered proactively to families who are at higher risk of poor outcomes due to known vulnerabilities such as young parental age, social isolation, housing instability or a history of trauma and this support aims to prevent problems before they occur and may include enhanced home visiting, parenting support or group-based interventions.

- **Targeted indicated support**

Targeted indicated support is provided when a specific concern has been identified - for example: a sensory impairment, delayed speech and language, mild to moderate mental health difficulties in a young person (and/or parent), atypical attachment and bonding or the

social impact of neurodiversity. All targeted interventions should be tailored to the family's circumstances and may be delivered (sometimes jointly with partner agencies) in home visits, clinics or community settings. Practitioners should be mindful that not all families are able or willing to attend group-based services, and home-based support may be essential to ensure equitable access.

Specialist level

At the specialist level, practitioners deliver substantial interventions for families requiring intensive or more complex care, based on ongoing assessment. Support at this level is often more comprehensive and longer term, and may involve:

- safeguarding concerns
- significant health vulnerabilities
- complex developmental needs

Support at this level also aims to strengthen relational safety and caregiving capacity, particularly where families are experiencing trauma, adversity or complex vulnerabilities. Practitioners should work in a trauma-informed way, promoting:

- trust
- emotional containment
- reflective engagement

Health visitors work closely with partner agencies (including social care, education, acute healthcare and mental health services) to plan and deliver integrated care that is responsive, co-ordinated and relationship focused.

The full guidance of the HCP can be found here.

High impact areas for health visiting

The high impact areas have been developed to meet public health priorities and improve outcomes for babies, children, young people and families. They are based on evidence of where these services can have the greatest impact and ensures that babies, children, young people and families receive the right support at the right time. The early years, from conception to age 5, are a time of monumental importance to a child's life, where brain development is rapid, secure attachments are forming and relationships begin to shape a child's emotional and social world. Health visitors and their teams can play a vital role in engaging with expectant parents and families, to support parents and babies to thrive. The high-impact areas for health visiting are:
:

- supporting transition to parenthood and the early weeks
- supporting maternal and infant mental health
- supporting breastfeeding (initiation and duration)
- supporting healthy weight and healthy nutrition
- improving health literacy; reducing accidents and minor illnesses
- supporting health, wellbeing and development. Ready to learn, narrowing the 'word gap



A bundle of indicators is available to measure performance and outcomes, for example through the Community Services Data Set (CSDS). Public Health Profiles are also available from the Child and Maternal Fingertips profile.

Health visitors

Health visitors, as public health nurses, use strength-based approaches, building non-dependent relationships to enable efficient and effective working with parents and families to support behaviour change, promote health protection and to keep children safe.

Health visitors also undertake a holistic assessment in partnership with the family, which builds on their strengths as well as identifying any difficulties. It includes the parents' capacity to meet their infant's needs, the impact and influence of wider family, community and environmental circumstances.

This period is an important opportunity for health promotion, prevention and early intervention approaches to be delivered. Working with parents and families, health visitors identify the most appropriate level of support and intervention for their individual needs.

Family Nurse Partnership

The Family Nurse Partnership (FNP) is an intensive, home visiting programme for first-time young parents and aims to improve children's life chances by supporting families during pregnancy and early childhood. The FNP benefits both parents and children, working primarily through the mother and provides an evidence based and targeted service for vulnerable families. Commissioning and providing FNP will improve the life chances of first-time young parents and their children, helping to break the cycle of disadvantage by building a consistent, trusting relationship between the family nurse and parent, which help to provide sensitive and responsive care for their children.

Local authorities commission the Family Nurse Partnership (FNP) programme, an evidence based, intensive parenting support intervention, as part of delivering the 0 to 5 public health offers for children as detailed in the Healthy Child Programme[4]. FNP teams recruit first-time mothers aged up to 24 based on local eligibility criteria and aim's to help young parents to:

- have a healthy pregnancy
- build strong, responsive relationships with their child
- make informed choices to support their child's development to given them the best possible start in life
- develop self-confidence and an ability to succeed
- apply the positive relationship with the family nurse to other areas of life

In their work with young parents, family nurses:

- help identify emerging needs, promote healthy behaviours and strengthen family resilience
- provide care in homes and communities, helping reduce reliance on acute services and putting in place preventative support close to where families live
- support families to access trusted digital resources, enhancing engagement and empowering parents to make informed decisions

FNP contributes to the Public Health Outcomes Framework (PHOF) for England which focuses on:

- increased healthy life expectancy
- reduced differences in life expectancy
- healthy life expectancy between communities

Specifically, FNP contributes to achieving the 6 early years high impact areas set out in the Healthy Child Programme (HCP) 0 to 19:

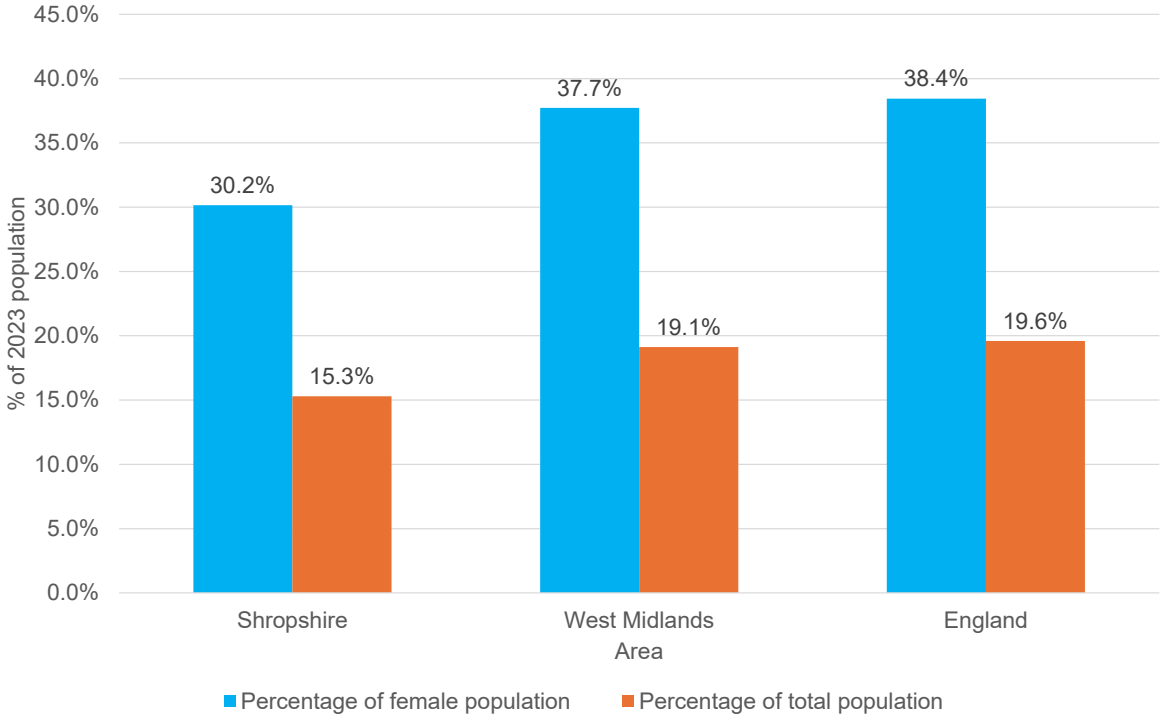
- supporting transition to parenthood and the early weeks
- supporting maternal and infant mental health
- supporting breastfeeding (initiation and duration)
- supporting healthy weight and healthy nutrition
- improving health literacy; reducing accidents and minor illnesses
- supporting health, wellbeing and development – ready to learn, narrowing the 'word gap'

[4] Best start in life and beyond- Family Nursing Partnership

Population profile

In Shropshire, there were 50,366 women aged 15 to 44 in 2023, which equates to 30.2% of the total female population and 15.3% of the total population. As a percentage of the female population, and the total population, Shropshire is lower than both the West Midlands and England[5]. For a more in-depth look at the population of Shropshire, please see Chapter 1: Population and context of the children and young people's joint strategic needs assessment[6]

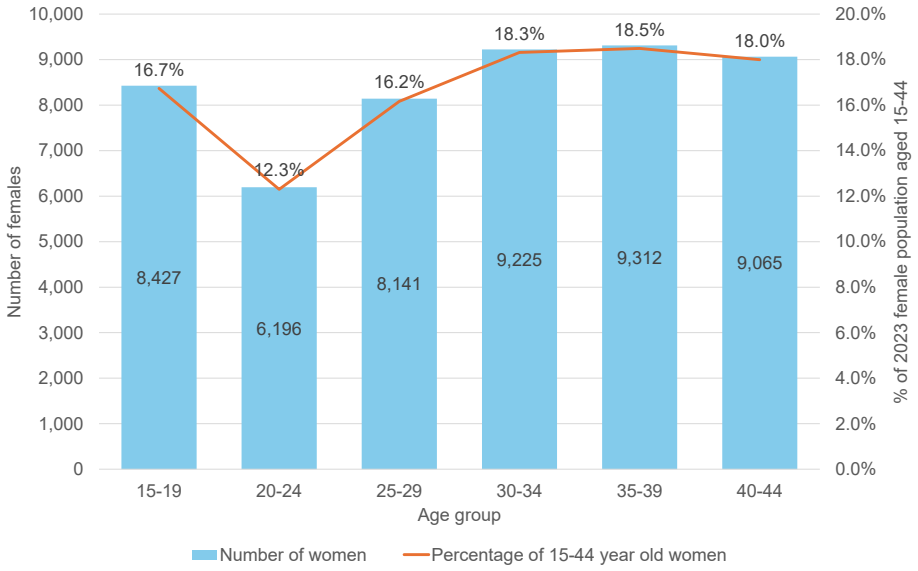
Female population aged 15-44 as a percentage of the total population, by area, 2023 mid-year population estimates. Source: 2023 Mid-year population estimates, ONS



Further analysis of Shropshire's female population aged 15-44 reveals a fairly even split between 5-year age groups, with those aged 30-34, 35-39 and 40-44 each accounting for over 9,000 women (18%), whilst the 20-24 age group accounted for the least in just under 6,200 (12.3%).

[5] Mid-2023 Population estimates, Office of National Statistics
[6] Chapter 1: Population and Context Chapter, CYP JSNA, Shropshire Council

Shropshire female population aged 15-44 by 5 year age group, 2023 mid-year population estimates. Source: 2023 Mid-year population estimates, ONS



Where do 15–44-year-old women live?

The highest number of 15–44-year-old females live in Bayston Hill, Column and Sutton ward (2,043), which accounts for 4.1% of all females of this age in the county, although this age group counts for 15.7% of that ward's total population[7]. Oswestry (1,623, 3.3%) and East and Market Drayton West (1,504, 3%) have the second and third highest numbers. The Quarry and Coton Hill ward actually has the highest percentage of its population that are female and aged 15-44 (22.5%).

Female 15–44-year-old population by electoral ward, (ONS mid 2020), Source: 2021 and 2022 Mid-year population estimates for electoral wards, ONS

Ward 2023 Name	15-44 Female population	% of Female 15–44 in county	Female 15-44 as % of ward's population
Abbey	725	1.5%	15.9%
Albrighton	730	1.5%	15.1%
Alveley and Claverley	516	1.0%	12.1%
Bagley	817	1.6%	17.2%
Battlefield	1,162	2.3%	19.4%
Bayston Hill, Column and Sutton	2,043	4.1%	15.7%
Belle Vue	700	1.4%	16.0%
Bishop's Castle	426	0.9%	11.7%
Bowbrook	762	1.5%	18.3%
Bridgnorth East and Astley Abbotts	873	1.8%	13.2%

[7] Mid-2021 and mid-2022 ward-level population estimates, ONS

Bridgnorth West and Tasley	1,035	2.1%	15.4%
Broseley	753	1.5%	14.5%
Brown Clee	640	1.3%	14.0%
Burnell	799	1.6%	16.2%
Castlefields and Ditherington	907	1.8%	19.3%
Cheswardine	689	1.4%	16.0%
Chirbury and Worthen	397	0.8%	13.4%
Church Stretton and Craven Arms	1,026	2.1%	11.7%
Clee	566	1.1%	12.6%
Cleobury Mortimer	931	1.9%	12.3%
Clun	413	0.8%	10.7%
Copthorne	622	1.3%	15.2%
Corvedale	423	0.9%	11.6%
Ellesmere Urban	648	1.3%	14.7%
Gobowen, Selattyn and Weston Rhyn	1,199	2.4%	17.0%
Harlescott	944	1.9%	18.3%
Highley	550	1.1%	14.5%
Hodnet	519	1.0%	10.8%
Llanymynech	598	1.2%	13.6%
Longden	628	1.3%	14.6%
Loton	636	1.3%	13.7%
Ludlow East	594	1.2%	15.5%
Ludlow North	433	0.9%	11.4%
Ludlow South	568	1.1%	14.0%
Market Drayton East	807	1.6%	15.0%
Market Drayton West	1,504	3.0%	16.1%
Meole	704	1.4%	16.0%
Monkmoor	728	1.5%	16.5%
Much Wenlock	539	1.1%	12.9%
Oswestry East	1,623	3.3%	17.2%
Oswestry South	722	1.5%	15.4%
Oswestry West	576	1.2%	15.7%
Porthill	805	1.6%	16.7%
Prees	599	1.2%	12.9%
Quarry and Coton Hill	981	2.0%	22.5%
Radbrook	1,056	2.1%	17.7%
Rea Valley	672	1.4%	15.1%
Ruyton and Baschurch	655	1.3%	15.0%
Severn Valley	702	1.4%	14.4%
Shawbury	813	1.6%	16.3%
Shifnal North	1,088	2.2%	17.7%
Shifnal South and Cosford	1,344	2.7%	16.8%
St Martin's	673	1.4%	14.3%
St Oswald	720	1.4%	14.6%
Sundorne	759	1.5%	18.3%
Tern	740	1.5%	14.9%
The Meres	608	1.2%	12.4%
Underdale	768	1.5%	18.0%
Wem	1,310	2.6%	14.6%
Whitchurch North	1,195	2.4%	15.8%
Whitchurch South	590	1.2%	14.2%
Whittington	716	1.4%	16.0%
Worfield	486	1.0%	13.0%
Total	**49,755**	**100.0%**	**15.2%**

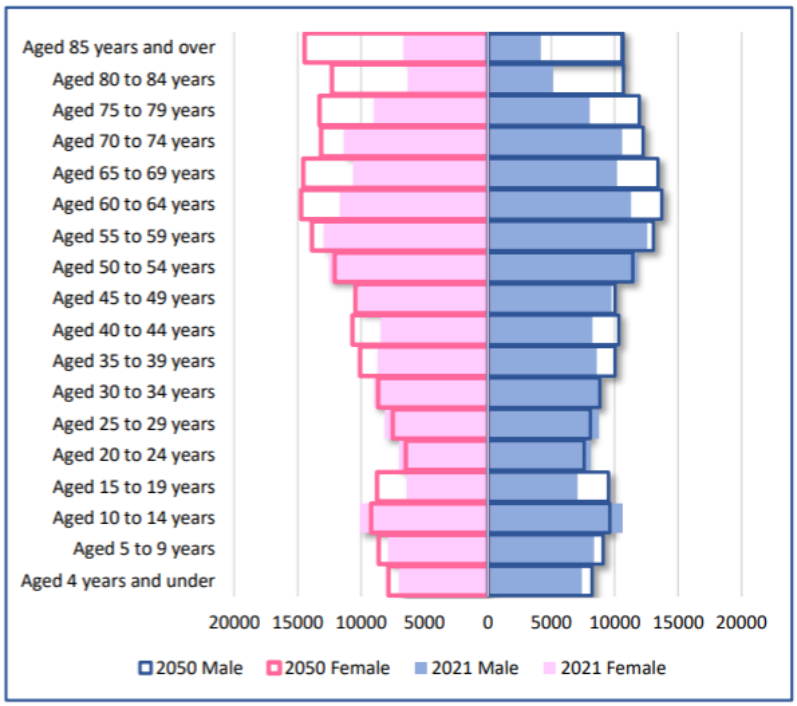
Future trends

Shropshire in 2050

The below population pyramid shows what Shropshire's population is projected to look like in 2050. Notably, Shropshire is an ageing population, and we expect to see a higher number of residents aged 65+.

There is a projected rise in the overall 15-44 female population by 2050, whilst the forecast is for a slight decrease in the 20-24 and 25-29 age groups and very similar numbers in the 30-34 age group, the 15-19 year female age group is predicted to rise the most, with increases too for women aged 35-39 and 40-44 which will become the largest age groups of women aged 15-44.

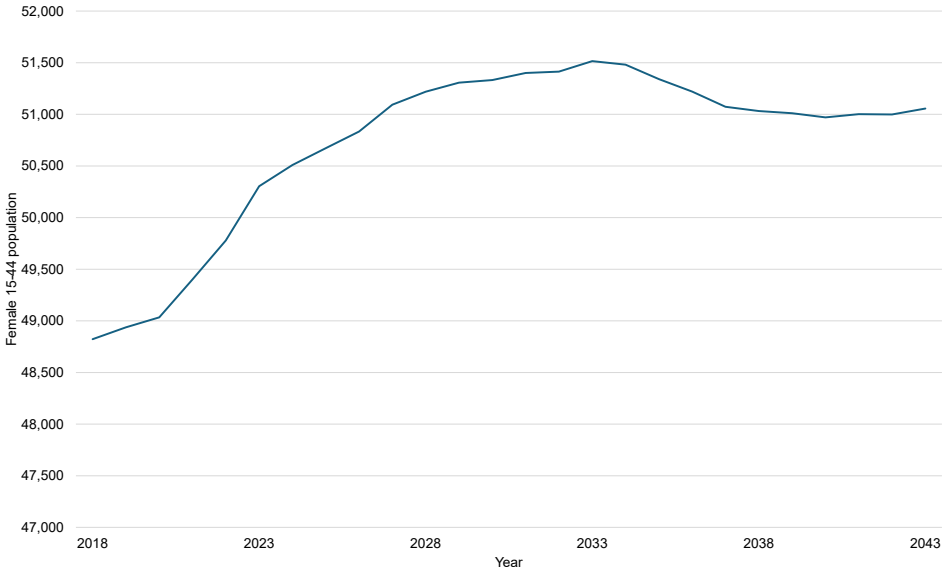
Chart showing population projections Shropshire between 2021 and 2050. Projections are SNPP to 2043, then rolled on to 2050 using PopGroup



The Office for National Statistics (ONS) population projections predict that the female 15 to 44 years population in Shropshire would increase by 5.5% (2,693) between 2023 and 2033 and by 4.6% between 2023 and 2043 (2,236)[8].

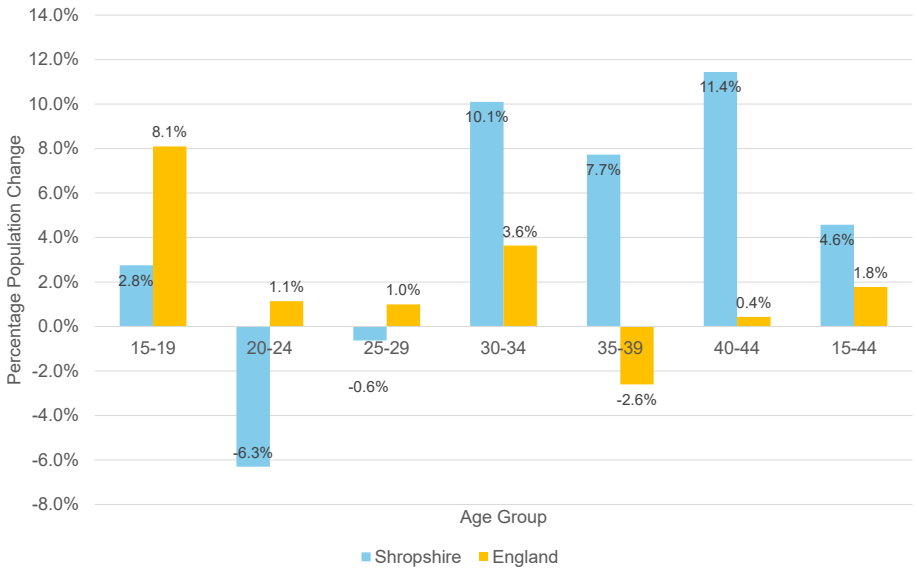
[8] Population projections for local authorities, ONS

Chart showing ONS population projections for 15–44-year-olds in Shropshire, 2023-2043, Source: Population projections for local authorities, ONS



The Office for National Statistics (ONS) population projections predict that the female 15 to 44 years population in Shropshire would increase by 4.6% between 2023 and 2043, as opposed to 1.8% in England. In more detail, there will be a decrease of 6.3% in 20-24 year olds and a decrease of 0.6% in 25-29 year olds, with increases in the population in other age groups, 15-19 (2.8%), 30-34 (10.1%), 35-39 (7.7%) and 40-44 (11.4%), which are very different percentage changes to England [9].

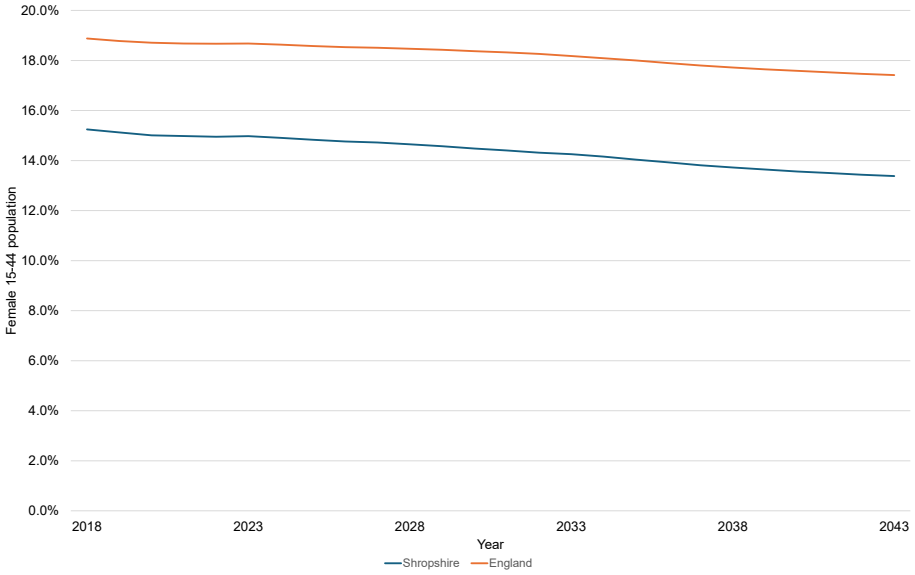
ONS percentage population projections change for 15–44-year-olds in Shropshire and England, 2023-2043, Source: Population projections for local authorities, ONS



[9] Population projections for local authorities, ONS

The Office for National Statistics (ONS) population projections predict that the female 15 to 44 years population as a percentage of the total population for Shropshire would fall from 15.2% in 2018 to 13.4% by 2043 – in England the percentage would fall from 18.9% to 17.4[10].

Chart showing ONS population projections for 15–44-year-olds in Shropshire and England as a percentage of total population, 2023-2043, Source: Population projections for local authorities, ONS



[10] Population projections for local authorities, ONS

Key statistics

High level summary

The department of health and social care have produced publicly available profiles for different topic areas which compare the performance of local authorities, ICBs, regions and England across a number of indicators as well as how they have done in previous years. These are known as Fingertips Public health profiles, available at this address: https://fingertips.phe.org.uk/profiles

Within the child and maternal health profile, the graphic below shows the Shropshire profile for 'pregnancy and birth' and these indicators are in line with assessing outcomes and the success of the Healthy Child Programme[11]: It should be noted that despite this being the most recent profile for pregnancy and birth, several of these indicators use old data that has not yet been updated, and also there are some indicators where there have been issues with submitting the data available for Shropshire, or data quality concerns. When this was the case and Shropshire was given an amber or red rating, attempts have been made to establish a more recent picture using other data in the following pages.

Indicator	Period	Shropshire			West Midlands	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Fertility and demographic information									
General fertility rate	2023	↓	2,427	47.8	53.0	49.4	30.8		67.2
Under 18s conception rate	2022	→	82	15.7	15.9	13.9	34.4		5.1
Under 18s births rate	2023	→	9	1.6	3.4	3.0	10.9		0.7
Deliveries to women aged 12 to 17	2023/24	→	-	*	0.6%	0.6%	-	*Insufficient number of values for a spine chart*	-
Deliveries to women aged 35 years and above	2023/24	→	65	22.4%*	21.2%	24.7%	14.2%		47.8%
Deliveries to women from ethnic minority groups	2023/24	→	10	3.4%*	34.6%	27.9%	2.1%		74.5%
Planning and preparation for pregnancy									
Early access to maternity care	2023/24	→	1,515	58.6%	61.2%	63.5%	16.6%		84.7%
Folic acid supplements taken before pregnancy ⚠	2023/24	↓	40	1.5%	8.0%	19.7%	0.5%		56.2%
Smoking in early pregnancy ⚠	2023/24	–	420	18.4%	13.0%	13.6%	-	*Insufficient number of values for a spine chart*	-
Obesity in early pregnancy ⚠	2023/24	–	-	*	28.7%	26.2%	-	*Insufficient number of values for a spine chart*	-
Smoking status at time of delivery	2024/25	↓	164	7.1%	6.2%	6.1%	13.2%		2.2%
Pregnancy and birth									
Stillbirth rate New data	2022 - 24	–	20	2.7	4.4	3.9	6.9		1.5
Premature births (less than 37 weeks gestation)	2020 - 22	–	547	70.2	82.6	77.0	106.8		52.3
Low birth weight of term babies	2024	→	44	2.0%	3.2%	3.0%	5.2%		1.7%
Low birth weight of all babies	2023	→	148	6.1%	8.1%	7.4%	11.2%		4.5%
Very low birth weight of all babies	2023	→	16	0.7%	1.3%	1.1%	2.4%		0.3%
Deliveries by caesarean section	2023/24	↑	120	41.4%*	40.2%	40.9%	56.2%		29.3%
Infant mortality rate	2022 - 24	–	29	3.9	6.1	4.2	8.7		1.2
Multiple births	2023	→	34	14.2	13.4	14.5	5.4		25.3
Admissions of babies under 14 days	2023/24	→	165	569.0*	99.4	88.7	679.2		16.3
Breastfeeding									
Baby's first feed breastmilk ⚠	2023/24	↑	1,720	81.7%	69.7%	71.9%	41.3%		94.3%
Breastfeeding prevalence at 6 to 8 weeks	2024/25	–	1,155	*	*	55.6%*	-	*Insufficient number of values for a spine chart*	-
Emergency admissions for gastroenteritis (0 to 4 years)	2023/24	→	125	88.7	80.3	67.6	243.2		12.6
Emergency admissions for lower respiratory tract infections (0 to 4 years)	2023/24	↑	295	209.4	201.6	207.7	486.3		80.9

Where Shropshire has gotten a red or amber rating for these indicators, there has been an attempt to look into it in more detail later.

[11] OHID Fingertips: Pregnancy and birth

General fertility rate

Fertility rates are closely tied to growth rates for an area and can be an excellent indicator of future population growth or decline in that area. This is defined as the birth rate per 1,000 females aged 15 to 44 years and is calculated by the number of live births occurring in the respective calendar year, divided by the female population estimates (aged 15-44) for the respective calendar year.

In 2023, there were 2,427 live births with a general fertility rate of 47.8 per 1,000 (down from 2,567 births and a rate of 51.6 in 2022), which was lower, but statistically similar to the national rate of 49.4, and significantly below the regional rate of 53.0. In 2023 Shropshire had the lowest fertility rate in the West Midlands, and when compared to Shropshire's nearest statistical neighbours, Shropshire sits fifth from bottom. Shropshire's fertility rate has now been similar to England's for the last 4 years and the decrease in Shropshire between 2022 and 2023 was the largest drop on record – and the 2023 rate is significantly lower than any year before 2022.

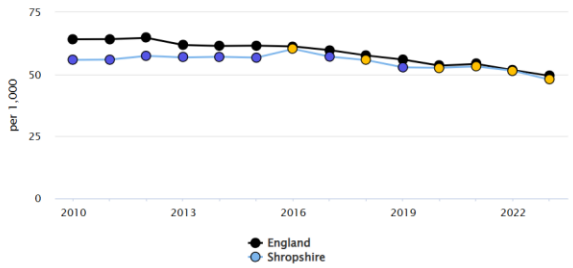
General fertility rate per 1,000 in Shropshire including regional neighbours, West Midlands and England, 2023. Source: Child and Maternal Health Profile, Fingertips, OHID

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	563,561	49.4	49.3	49.5
West Midlands region (statistical)	↓	62,126	53.0	52.6	53.4
Wolverhampton	→	3,407	61.3	59.3	63.4
Sandwell	→	4,351	60.2	58.4	62.0
Walsall	↓	3,347	58.6	56.7	60.7
Stoke-on-Trent	↓	2,948	56.0	54.0	58.1
Dudley	↓	3,341	55.5	53.6	57.4
Birmingham	↓	14,238	53.6	52.7	54.4
Telford and Wrekin	↓	1,924	51.8	49.5	54.2
Herefordshire	→	1,498	51.5	48.9	54.2
Warwickshire	↓	5,728	50.5	49.2	51.8
Solihull	↓	1,939	50.4	48.2	52.7
Coventry	↓	4,036	50.4	48.8	51.9
Staffordshire	↓	7,739	50.0	48.9	51.1
Worcestershire	↓	5,203	49.3	48.0	50.7
Shropshire	↓	2,427	47.8	46.0	49.8

General fertility rate in Shropshire including nearest statistical neighbours, with England comparison, 2023. Source: Child and Maternal Health Profile, Fingertips, OHID

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↓	-	563,561	49.4	49.3	49.5
Neighbours average	–	-	-	-	-	-
Herefordshire	→	3	1,498	51.5	48.9	54.2
Suffolk	↓	8	6,615	51.1	49.9	52.3
Somerset UA	↓	4	4,734	50.8	49.3	52.2
Wiltshire	↓	2	4,350	50.6	49.1	52.1
Cheshire East	↓	15	3,542	50.2	48.6	51.9
West Berkshire	→	13	1,435	50.2	47.6	52.9
Gloucestershire	↓	9	5,839	49.9	48.6	51.2
North Yorkshire UA	↓	1	4,777	49.4	48.0	50.9
Northumberland	→	10	2,486	49.3	47.3	51.2
Cumberland	↓	7	2,256	49.2	47.2	51.2
East Riding of Yorkshire	↓	6	2,591	48.5	46.7	50.5
Shropshire	↓	-	2,427	47.8	46.0	49.8
Westmorland and Furness	↓	5	1,642	46.6	44.4	49.0
Cornwall	↓	11	4,346	46.3*	45.0	47.7
Dorset	↓	12	2,412	44.5	42.8	46.4
Devon	↓	14	6,007	44.0	42.9	45.2

General fertility rate per 1,000 in Shropshire including regional neighbours, West Midlands and England, 2010 to 2023. Source: Child and Maternal Health Profile, Fingertips, OHID



Recent trend: ⬇ Decreasing

Period		Shropshire Count	Value	95% Lower CI	95% Upper CI	England
2010		2,889	55.8	53.8	57.9	64.1
2011		2,879	55.9	53.9	58.0	64.2
2012		2,913	57.5	55.4	59.6	64.7
2013		2,844	56.8	54.8	59.0	61.8
2014		2,834	57.1	55.0	59.2	61.5
2015		2,795	56.7	54.6	58.9	61.6
2016		2,947	60.2	58.1	62.4	61.2
2017		2,793	57.1	55.0	59.3	59.7
2018		2,713	55.7	53.6	57.9	57.6
2019		2,587	52.8	50.8	54.9	55.9
2020		2,578	52.6	50.6	54.7	53.5
2021		2,639	53.2	51.2	55.2	54.2
2022		2,567	51.5	49.5	53.5	51.7
2023		2,427	47.8	46.0	49.8	49.4

Source: OHID, based on Office for National Statistics data

Overall, fertility and birth rates in Shropshire have been falling in the last few years, for example the general fertility rate per 1,000 females falling to 46.8 births in 2024 and the total fertility rate falling to 1.40. The age specific fertility rates have fallen in each age group besides under 18s and those over 40, which have increased, and the average age of mothers in Shropshire has increase to 30.5 from 30.2.

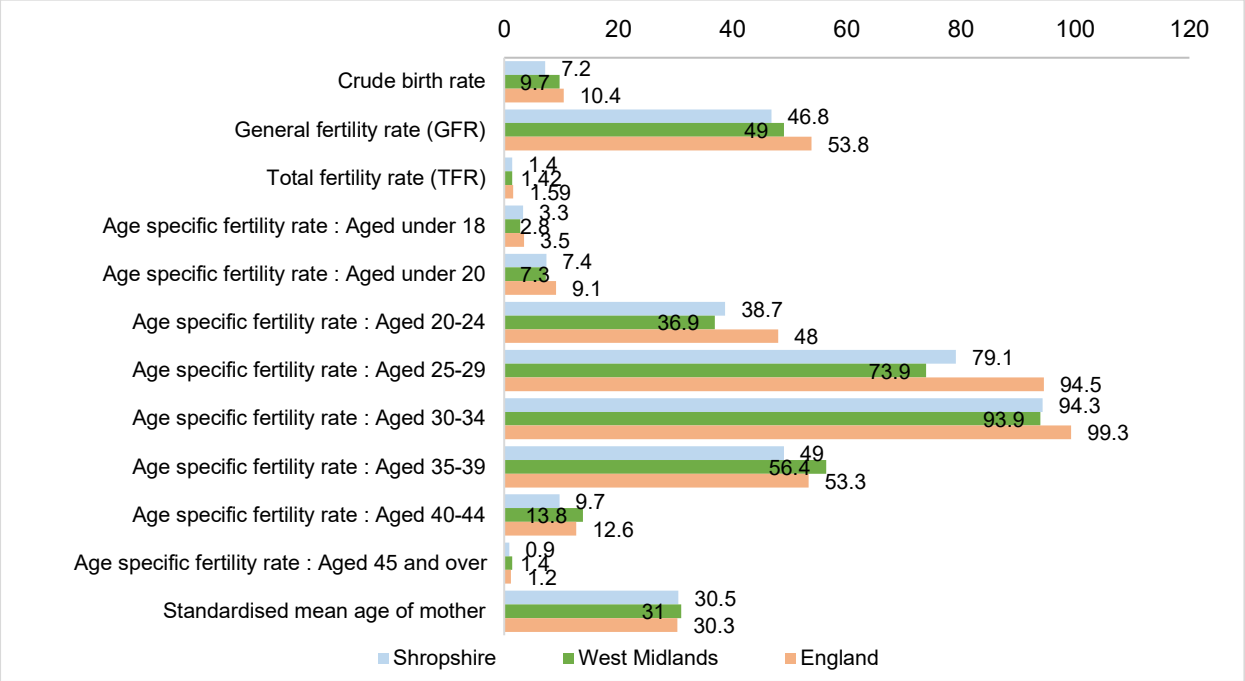
Live births, birth rates and mean age of mother in Shropshire, 2022-24. Source: Live births in England and Wales: birth rates down to local authority areas, NOMIS[12]

Shropshire	**2022**	**2023**	**2024**
Live births	2,567	2,427	2,406
Crude birth rate	7.8	7.4	7.2
General fertility rate (GFR)	51.5	47.8	46.8
Total fertility rate (TFR)	1.53	1.43	1.40
Age specific fertility rate : Aged under 18	2.1	1.6	3.3
Age specific fertility rate : Aged under 20	9.3	5.6	7.4
Age specific fertility rate : Aged 20-24	48.3	44.3	38.7
Age specific fertility rate : Aged 25-29	85.4	82.2	79.1
Age specific fertility rate : Aged 30-34	99.2	93.7	94.3
Age specific fertility rate : Aged 35-39	53.4	46.8	49.0
Age specific fertility rate : Aged 40-44	9.3	12.0	9.7
Age specific fertility rate : Aged 45 and over	0.5	0.9	0.9
Standardised mean age of mother	30.2	30.4	30.5

In 2024, Shropshire had a lower crude birth rate (7.2 births per 1,000 females), compared to the West Midlands region (9.7) and England (10.4) [13], and the general fertility rate (46.8) was also lower than both too. In Shropshire, fertility rates of mothers in each age group were lower than in England, however, they are only lower than the West Midlands in the age groups above 35 years old, whilst being higher in those age groups below this.

[12] NOMIS Live births in England and Wales : birth rates down to local authority areas
[13] Live births in England and Wales : birth rates down to local authority areas

Birth rates and fertility rates in Shropshire, including West Midlands and England, 2024. Source: Live births in England and Wales: birth rates down to local authority areas, NOMIS[14]



The general fertility rate varies in different parts of Shropshire. The 'local health, public health data for small geographical areas' profile[15], allows for the general fertility rate to be compared between middle level super output areas (MSOA) in Shropshire for the five-year period 2018-22. In this five-year period Shropshire's fertility rate was 53.1 per 1,000 women.

The Shifnal MSOA (64.3) had the highest rate in Shropshire with Hinstock & Hodnet (61.1), Shrewsbury Harlescott & Sundorne (60.1), Shrewsbury Harlescott Grange (59.9) and Whitchurch (59.5) all being significantly above Shropshire's rate.

In contrast, seven MSOAs were significantly below Shropshire's rate -Much Wenlock & Broseley (47.3), Alveley, Claverley & Worfield (44.1), Shrewsbury Meole & Kingsland (44.0), Shrewsbury Town (42.3), Bridgnorth East (42.3), Church Stretton (40.9) and Cressage, Dorrington & Pulverbatch (37.4) having the lowest in Shropshire.

[14] NOMIS Live births in England and Wales : birth rates down to local authority areas

[15] Local health, public health data for small geographic areas - OHD (phe.org.uk)

General fertility rate per 1,000 in Shropshire by MSOA, 2018 to 2022. Source: Local health, public health data for small geographical areas, Fingertips, OHID

Area	Count	Value	95% Lower CI	95% Upper CI
England	2,994,345	54.6	54.5	54.7
Shropshire	13,084	53.1	52.2	54.1
Shifnal	584	64.3	59.2	69.7
Hinstock & Hodnet	306	61.1	54.4	68.3
Craven Arms & Broadstone	268	60.3	53.3	68.0
Shrewsbury Harlescott & Sundorne	525	60.1	55.1	65.5
Shrewsbury Harlescott Grange	460	59.9	54.6	65.6
Bayston Hill & Atcham	386	59.9	54.0	66.1
Whitchurch	482	59.5	54.3	65.0
Shrewsbury Copthorne & Bowbrook	539	59.0	54.1	64.2
Shrewsbury Monkmoor	456	58.8	53.5	64.4
Shawbury & Weston	279	58.1	51.4	65.3
Woore, Prees & Tilstock	315	58.0	51.7	64.7
Oswestry East	506	57.8	52.8	63.0
Market Drayton	587	57.7	53.2	62.6
Hanwood, Pontesbury & Minsterley	334	56.8	50.9	63.3
Cleobury Mortimer, Burford & Ashford Carbonell	314	55.6	49.6	62.1
Gobowen, St Martin's & Weston Rhyn	482	55.5	50.6	60.7
Shrewsbury Greenfields	440	53.1	48.3	58.4
Shrewsbury Sutton & Coleham	300	52.9	47.1	59.3
Ludlow Town	393	52.6	47.5	58.1
Wem	248	52.4	46.1	59.3
Trefonen & Pant	196	52.3	45.2	60.2
Clun & Bucknell	175	51.6	44.2	59.8
Oswestry West	386	50.8	45.9	56.1
Highley & Ditton Priors	332	50.5	45.2	56.2
Ruyton-XI-Towns, West Felton & Whittington	267	50.4	44.5	56.8
Ellesmere	279	50.2	44.5	56.5
Bishop's Castle, Brockton & Chirbury	183	49.2	42.4	56.9
Baschurch, Cockshutt & Harmer Hill	300	48.1	42.8	53.8
Bomere Heath & Montford Bridge	341	47.8	42.9	53.2
Bridgnorth West	194	47.4	41.0	54.6
Much Wenlock & Broseley	408	47.3	42.8	52.1
Cosford & Albrighton	259	47.2	41.6	53.3
Shrewsbury London Road	172	45.7	39.2	53.1
Alveley, Claverley & Worfield	217	44.1	38.4	50.3
Shrewsbury Meole & Kingsland	355	44.0	39.5	48.8
Shrewsbury Town	305	42.3	37.7	47.3
Bridgnorth East	173	42.3	36.2	49.1
Church Stretton	122	40.9	34.0	48.8
Cressage, Dorrington & Pulverbatch	216	37.4	32.6	42.8

Under 18 conceptions (teenage pregnancy)

Most teenage pregnancies are unplanned and around half end in an abortion. As well as it being an avoidable experience for the young woman, abortions represent an avoidable cost to the NHS[16]. And while for some young women having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child, in terms of the baby's health, the mother's emotional health and well-being and the likelihood of both the parent and child living in long-term poverty[22].

Research evidence, particularly from longitudinal studies, shows that teenage pregnancy is associated with poorer outcomes for both young parents and their children[22]. Teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers[22]. The children of teenage mothers have an increased risk of living in

[16] Public health profiles - OHID (phe.org.uk)

poverty and poor-quality housing and are more likely to have accidents and behavioural problems[22].

There are limited local data available on the demographics of teenagers who become pregnant due to the small numbers of teenage conceptions. However, based on national data, the Teenage Pregnancy Prevention Framework suggests that the following are risk factors for teenage conception [17]:

- Poverty
- Persistent school absence by year 9
- First sex before 16 years of age
- Children in care and care leavers
- Lesbian or bisexual experience
- Alcohol use
- Previous pregnancy
- Mother was a teenage parent

In 2022 there were 82 pregnancies among girls and women aged under 18 (up from 65 in 2021), equating to rate of 12.5 per 1,000 population (increase from 12.5), similar to the national rate of 13.9 and below the regional rate of 15.9. This ranks Shropshire sixth lowest in the West Midlands[18]. Shropshire's rate is statistically similar to most of its nearest statistical neighbours but is the fourth highest of them. Shropshire's conception rates have gone up in each of the last five years, and the number and rate are the highest since 2015, although the rate now is still statistically similar to each year since 2012.

Under 18s conception rate per 1,000 in Shropshire including regional neighbours, West Midlands and England, 2022. Source: Child and Maternal Health Profile, Fingertips, OHID

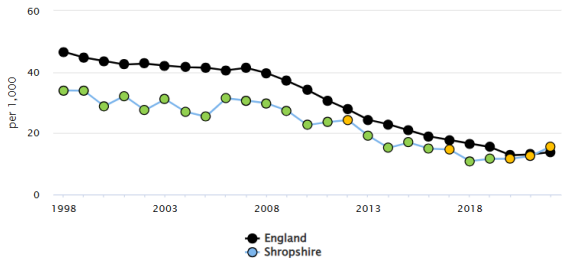
Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	13,424	13.9	13.7	14.1
West Midlands region (statistical)	↓	1,704	15.9	15.2	16.7
Stoke-on-Trent	→	99	21.8	17.7	26.5
Coventry	→	128	21.2	17.7	25.3
Dudley	→	106	19.0	15.6	23.0
Walsall	↓	98	17.9	14.6	21.8
Sandwell	↓	116	17.0	14.0	20.4
Wolverhampton	↓	81	16.2	12.9	20.2
Staffordshire	→	225	15.9	13.9	18.1
Telford and Wrekin	→	55	15.8	11.9	20.6
Shropshire	→	82	15.7	12.5	19.5
Warwickshire	→	156	15.6	13.2	18.2
Birmingham	↓	343	14.5	13.0	16.1
Herefordshire	→	39	14.1	10.0	19.3
Solihull	→	53	13.7	10.3	17.9
Worcestershire	→	123	12.0	9.9	14.3

[17] Teenage pregnancy prevention framework 2018
[18] Child and Maternal Health - Data - OHID (phe.org.uk)

Under 18s conception rate in Shropshire including nearest statistical neighbours, with England comparison, 2022. Source: Child and Maternal Health Profile, Fingertips, OHID

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↓	-	13,424	13.9	13.7	14.1
Neighbours average	–	-	-	-	-	-
Cumberland	→	7	74	17.5	13.8	22.0
Northumberland	→	10	84	17.3	13.8	21.4
Cornwall	→	11	147	16.5*	14.0	19.4
Shropshire	→	-	82	15.7	12.5	19.5
Suffolk	→	8	180	14.6	12.5	16.9
Herefordshire	→	3	39	14.1	10.0	19.3
Devon	→	14	170	13.6	11.6	15.8
East Riding of Yorkshire	→	6	65	12.1	9.3	15.4
Cheshire East	→	15	79	12.0	9.5	15.0
Somerset UA	→	4	115	11.8	9.7	14.2
Gloucestershire	→	9	127	11.7	9.8	14.0
North Yorkshire UA	→	1	117	11.6	9.6	13.9
Westmorland and Furness	→	5	34	9.6	6.7	13.4
Wiltshire	→	2	80	9.1	7.2	11.3
Dorset	→	12	51	8.5	6.3	11.1
West Berkshire	→	13	23	7.4	4.7	11.1

Under 18s conception rate per 1,000 in Shropshire including regional neighbours, West Midlands and England, 1998 to 2022. Source: Child and Maternal Health Profile, Fingertips, OHID



Recent trend: → No significant change

Period		Shropshire Count	Value	95% Lower CI	95% Upper CI	West Midlands	England
1998	●	177	34.0	29.2	39.4	51.7	46.6
1999	●	171	33.9	29.0	39.4	49.3	44.8
2000	●	144	28.9	24.3	34.0	49.0	43.6
2001	●	165	32.2	27.5	37.5	47.2	42.5
2002	●	143	27.5	23.2	32.4	47.0	42.8
2003	●	165	31.1	26.5	36.2	47.4	42.1
2004	●	148	27.0	22.8	31.7	45.2	41.6
2005	●	144	25.4	21.5	30.0	45.7	41.4
2006	●	185	31.4	27.1	36.3	46.3	40.6
2007	●	183	30.7	26.4	35.5	46.6	41.4
2008	●	176	29.8	25.6	34.6	43.2	39.7
2009	●	160	27.4	23.3	32.0	42.1	37.1
2010	●	131	22.7	18.9	26.9	38.5	34.2
2011	●	136	23.7	19.8	28.0	34.9	30.7
2012	●	137	24.3	20.4	28.7	32.0	27.8
2013	●	107	19.2	15.7	23.2	28.9	24.4
2014	●	85	15.2	12.1	18.8	26.6	22.9
2015	●	93	17.0	13.7	20.8	23.7	20.9
2016	●	81	15.0	11.9	18.6	21.4	19.0
2017	●	79	14.7	11.6	18.3	19.8	17.8
2018	●	58	10.9	8.3	14.1	18.9	16.6
2019	●	62	11.6	8.9	14.9	17.9	15.5
2020	●	62	11.7	8.9	15.0	14.8	12.8
2021	●	65	12.5	9.7	16.0	15.2	13.1
2022	●	82	15.7	12.5	19.5	15.9	13.9

Under 16 conceptions (teenage pregnancy)

In 2022, there were 15 pregnancies among under 16-year-olds in Shropshire, equating to a rate of 2.8 per 1,000, up from 14 pregnancies with a rate of 2.7 in 2021. This ranks Shropshire sixth lowest in the West Midlands region, which has a rate of 2.5 per 1,000. Compared to its statistical neighbours, Shropshire ranks as the third highest but is statistically similar to all other neighbours. In Shropshire, the rate of Under 16 pregnancy's had generally been decreasing since 2009, but the 2022 figure is the highest since 2017, however, Shropshire remains statistically similar to the national average of 2.2 per 1,000.

Under 16s conception rate per 1,000 in Shropshire including regional neighbours, West Midlands and England, 2022. Source: Child and Maternal Health Profile, Fingertips, OHID

C02b - Under 16s conception rate **New data** 2022 — Crude rate - per 1,000

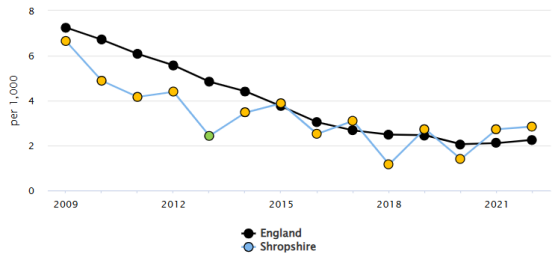
Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	2,258	2.2	2.2	2.3
West Midlands region (statistical)	→	281	2.5	2.3	2.9
Stoke-on-Trent	→	24	4.8	3.1	7.2
Telford and Wrekin	→	17	4.8*	2.8	7.7
Walsall	→	20	3.5	2.1	5.4
Coventry	→	21	3.3	2.0	5.0
Dudley	→	17	3.0*	1.8	4.9
Shropshire	→	15	2.8*	1.6	4.7
Wolverhampton	→	14	2.6*	1.4	4.4
Birmingham	→	60	2.5	1.9	3.2
Staffordshire	→	35	2.4	1.6	3.3
Sandwell	→	13	1.8*	1.0	3.1
Worcestershire	→	18	1.8*	1.0	2.8
Herefordshire	→	5	1.7*	0.6	4.1
Warwickshire	→	17	1.6*	0.9	2.6
Solihull	→	5	1.3*	0.4	2.9

Under 16s conception rate per 1,000 in Shropshire including nearest statistical neighbours, and England, 2022. Source: Child and Maternal Health Profile, Fingertips, OHID

C02b - Under 16s conception rate **New data** 2022 — Crude rate - per 1,000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↓	-	2,258	2.2	2.2	2.3
Neighbours average	–	-	-	-	-	-
Cumberland	–	7	16	3.7*	2.1	6.0
Northumberland	→	10	18	3.5*	2.1	5.6
Shropshire	→	-	15	2.8*	1.6	4.7
Cornwall	→	11	23	2.5*	1.6	3.8
Cheshire East	→	15	16	2.4*	1.4	3.8
Suffolk	→	8	25	2.0	1.3	2.9
Gloucestershire	→	9	21	1.8	1.1	2.8
Somerset UA	→	4	18	1.8*	1.1	2.9
Herefordshire	→	3	5	1.7*	0.6	4.1
Devon	→	14	22	1.7	1.1	2.6
Wiltshire	→	2	15	1.6*	0.9	2.7
North Yorkshire UA	→	1	15	1.5*	0.8	2.4
Westmorland and Furness	–	5	5	1.4*	0.5	3.4
East Riding of Yorkshire	→	6	6	1.1*	0.4	2.4
West Berkshire	→	13	3	0.9*	0.2	2.6
Dorset	→	12	5	0.8*	0.3	1.8

Under 16s conception rate per 1,000 in Shropshire, with England comparison, 2009 to 2022. Source: Child and Maternal Health Profile, Fingertips, OHID



Recent trend: → No significant change

Period		Shropshire Count	Value	95% Lower CI	95% Upper CI	Neighbrs average	England
2009		37	6.7	4.7	9.2	-	7.3
2010		27	4.9	3.2	7.1	-	6.7
2011		23	4.2	2.6	6.2	-	6.1
2012		24	4.4	2.8	6.5	-	5.6
2013		13	2.4	1.3	4.1	-	4.8
2014		18	3.5	2.1	5.5	-	4.4
2015		20	3.9	2.4	6.0	-	3.7
2016		13	2.5	1.3	4.3	-	3.0
2017		16	3.1	1.8	5.0	-	2.7
2018		6	1.2	0.4	2.5	-	2.5
2019		14	2.7	1.5	4.6	-	2.5
2020		7	1.4	0.6	2.9	-	2.1
2021		14	2.7	1.5	4.6	-	2.1
2022		15	2.8*	1.6	4.7	-	2.2

Under 18s birth rate / 1,000

Teenage parents are at increased risk of postnatal depression and poor mental health in the 3 years following birth. They are more likely than older mothers to have low educational attainment, experience adult unemployment and be living in poverty at age 30. Their children experience higher rates of infant mortality and low birth weight, A&E admissions for accidents and have a much higher risk of being born into poverty.

This is defined as the number of live births in women aged under 18 per 1,000 females aged 15-17. In 2023, Shropshire had a under 18s birth rate per 1,000 of 1.6 (9 births), which is statistically similar to England (3.0), but significantly below the West Midlands (3.4) and is the second lowest in the region and the fourth lowest among nearest statistical neighbours. The trends show that the figure for Shropshire have always been below England's back to 2009, mostly significantly below, but in the last 2 years it has been statistically similar due to a small increase in the already small birth numbers among under 18-year-olds in Shropshire.

Under 18s birth rate per 1,000 in Shropshire including regional neighbours, West Midlands and England, 2023. Source: Child and Maternal Health Profile, Fingertips, OHID

Under 18s births rate 2023 — Crude rate - per 1,000

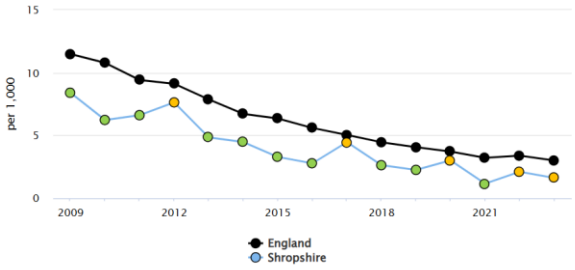
Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	3,010	3.0	2.9	3.1
West Midlands region (statistical)	↓	380	3.4	3.1	3.8
Stoke-on-Trent	→	31	6.3	4.3	9.0
Sandwell	→	42	6.0	4.3	8.1
Telford and Wrekin	→	20	5.6	3.4	8.6
Walsall	→	29	5.1	3.4	7.4
Coventry	→	28	4.4	2.9	6.4
Dudley	→	23	4.0	2.6	6.1
Wolverhampton	→	19	3.5	2.1	5.5
Staffordshire	→	51	3.5	2.6	4.6
Birmingham	↓	74	3.1	2.4	3.9
Herefordshire	→	7	2.5	1.0	5.1
Warwickshire	→	24	2.3	1.5	3.4
Worcestershire	→	19	1.8	1.1	2.8
Shropshire	→	9	1.6	0.7	3.1
Solihull	→	4	1.0	0.3	2.6

Under 18s birth rate per 1,000 in Shropshire including nearest statistical neighbours, with England comparison, 2023. Source: Child and Maternal Health Profile, Fingertips, OHID

Under 18s births rate 2023 — Crude rate - per 1,000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↓	-	3,010	3.0	2.9	3.1
Neighbours average	–	-	-	-	-	-
Northumberland	→	10	25	4.9	3.2	7.2
Suffolk	→	8	57	4.5	3.4	5.8
Cumberland	→	7	18	4.1	2.4	6.5
Cheshire East	→	15	19	2.8	1.7	4.4
North Yorkshire UA	→	1	29	2.8	1.9	4.0
Somerset UA	→	4	28	2.8	1.8	4.0
Cornwall	→	11	24	2.6*	1.7	3.9
Herefordshire	→	3	7	2.5	1.0	5.1
Devon	→	14	32	2.5	1.7	3.5
Westmorland and Furness	→	5	8	2.2	1.0	4.4
Gloucestershire	→	9	25	2.2	1.4	3.2
East Riding of Yorkshire	→	6	11	2.0	1.0	3.6
Shropshire	→	-	9	1.6	0.7	3.1
West Berkshire	→	13	5	1.5	0.5	3.4
Wiltshire	→	2	9	1.0	0.4	1.9
Dorset	→	12	5	0.8	0.3	1.9

Under 18s birth rate per 1,000 in Shropshire, West Midlands and England, 2009 to 2023.
Source: Child and Maternal Health Profile, Fingertips, OHID



Recent trend: No significant change

Period		Shropshire Count	Value	95% Lower CI	95% Upper CI	Neighbrs average	England
2009		49	8.4	6.2	11.1	-	11.5
2010		36	6.2	4.4	8.6	-	10.8
2011		38	6.6	4.7	9.1	-	9.4
2012		43	7.6	5.5	10.3	-	9.1
2013		27	4.8	3.2	7.0	-	7.9
2014		25	4.5	2.9	6.6	-	6.7
2015		18	3.3	1.9	5.2	-	6.3
2016		15	2.8	1.5	4.6	-	5.6
2017		24	4.5	2.9	6.6	-	5.0
2018		14	2.6	1.4	4.4	-	4.5
2019		12	2.3	1.2	3.9	-	4.1
2020		16	3.0	1.7	4.9	-	3.7
2021		6	1.2	0.4	2.5	-	3.2
2022		11	2.1	1.0	3.8	-	3.4
2023		9	1.6	0.7	3.1	-	3.0

Early access to maternity care

A pregnant woman's booking appointment allows scheduling of her ultrasound scan, identification of women who might need more than usual care, either because of medical history or social circumstances, for discussion of antenatal screening, taking blood pressure and measuring the woman's height and weight, identification of risk factors such as smoking and offering support, discussion of mood and mental health.

It also ensures the mother's details can be shared in good time with the health visiting service, who visit the mother at home during the last three months of her pregnancy for promotion of health and wellbeing and planning for parenthood, and to arrange for more intense support following the birth, where needed.

Historically, the proportion of women who had seen a midwife for their booking appointment by 12 weeks and 6 days of their pregnancy was monitored by Department of Health as a national indicator, and then by NHS England. Women booking after 20 weeks are considered at particularly high risk as they have missed the window of opportunity for screening for particular infectious diseases, for inherited conditions and for Down's, Edwards' and Patau's syndrome. Inadequate use of antenatal care has been shown to be strongly independently associated with increased odds of maternal death. This indicator is defined as the percentage of pregnant women who have their booking appointment with a midwife within 10 completed weeks of their pregnancy.

In 2023/24, the percentage of women with early access to maternity care was 58.6% in Shropshire which is significantly below England (63.5%) and West Midlands (61.2%) and is the fifth lowest in the region. Shropshire has the lowest figure among its nearest statistical neighbours, being significantly lower than all but two areas. Shropshire's figures have decreased year on year since 2019/20 and been below England's for the last 4 years – 3 of these significantly below.

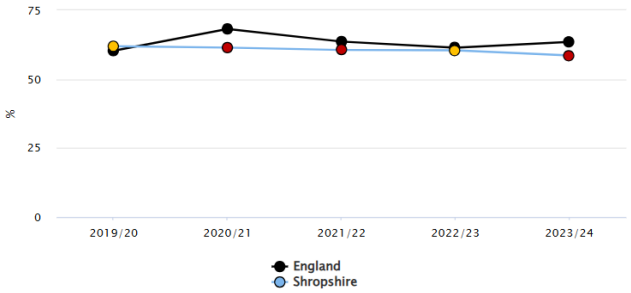
Early access to maternity care in Shropshire including regional neighbours, West Midlands and England, 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	397,575	63.5	63.4	63.7
West Midlands region (statistical)	↓	43,605	61.2	60.8	61.6
Solihull	→	1,690	77.3	75.6	79.1
Dudley	↓	2,715	71.9	70.4	73.3
Staffordshire	→	5,975	71.4	70.4	72.4
Warwickshire	→	4,585	71.1	70.0	72.2
Sandwell	→	3,705	67.8	66.5	69.0
Wolverhampton	↓	2,650	65.8	64.3	67.2
Herefordshire	↓	1,035	62.5	60.1	64.7
Stoke-on-Trent	↓	2,130	60.9	59.3	62.5
Birmingham	→	10,185	60.0	59.2	60.7
Shropshire	→	1,515	58.6	56.6	60.4
Coventry	↓	2,710	55.8	54.4	57.1
Walsall	↓	1,975	51.2	49.5	52.7
Telford and Wrekin	↓	940	45.1	43.0	47.2
Worcestershire	↓	1,795	32.9	31.7	34.2

Early access to maternity care in Shropshire including nearest statistical neighbours and England, 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	→	-	397,575	63.5	63.4	63.7
Neighbours average	–	-	-	-	-	-
Wiltshire	→	2	3,950	82.0	81.0	83.1
East Riding of Yorkshire	→	6	2,000	79.8	78.2	81.3
Northumberland	→	10	2,070	77.8	76.2	79.4
West Berkshire	→	13	1,145	77.6	75.3	79.6
North Yorkshire UA	→	1	4,110	76.4	75.3	77.5
Devon	→	14	5,105	76.3	75.2	77.3
Suffolk	→	8	5,130	75.9	75.0	77.0
Westmorland and Furness	↓	5	1,370	75.9	74.1	78.0
Dorset	↑	12	2,035	73.5	71.8	75.1
Cornwall	→	11	3,370	73.2*	71.9	74.4
Cheshire East	→	15	2,910	72.2	70.9	73.7
Cumberland	→	7	1,810	72.0	70.2	73.7
Somerset UA	→	4	3,350	63.7	62.5	65.1
Herefordshire	↓	3	1,035	62.5	60.1	64.7
Gloucestershire	→	9	3,895	60.6	59.4	61.8
Shropshire	→	-	1,515	58.6	56.6	60.4

Early access to maternity care in Shropshire, with England comparison, 2019-20 to 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID



Recent trend: → No significant change

Period	Shropshire				Neighbrs average	England
		Count	Value	95% Lower CI	95% Upper CI		
2019/20		1,710	62.0%	60.2%	63.8%	-	60.3%
2020/21		1,705	61.4%	59.6%	63.2%	-	68.2%
2021/22		1,615	60.6%	58.8%	62.5%	-	63.6%
2022/23		1,600	60.5%	58.5%	62.2%	-	61.4%
2023/24		1,515	58.6%	56.6%	60.4%	-	63.5%

Source: OHID, based on NHS England data

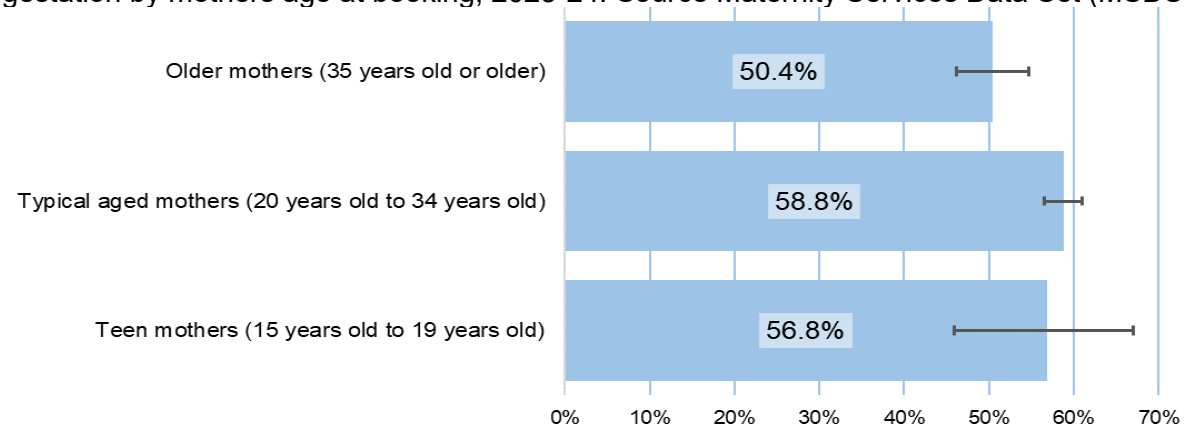
Indicator Definitions and Supporting Information

Local data

The Shropshire, Telford and Wrekin Local Maternity and System (LMNS) dashboard reports that for the most recent financial period, 2023-24, just 55% of women from Shropshire received their first antenatal appointment within 10 weeks.

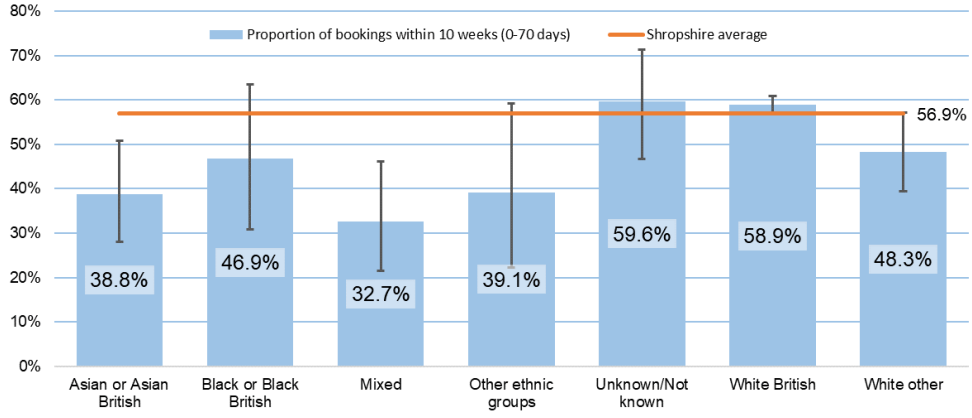
Local analysis using data extracted from the national Maternity Services Data Set (MSDS), covering the same period, April 2023 to March 2024, identified 2,464 bookings recorded to persons living within the Shropshire area, of whom just 56.9% recorded their first antenatal booking appointment within 10 weeks. Analysis found that the mothers age did not seem to be a factor as to whether a mother recorded her first booking appointment within 10 weeks, with mothers (Under 20), typical age mothers (20-34) and older mothers (35+) all found to have statistically similar rates of mothers booked within 10 weeks.

Proportion of mothers recording their first antenatal appointment within 10-weeks of gestation by mothers age at booking, 2023-24. Source Maternity Services Data Set (MSDS)



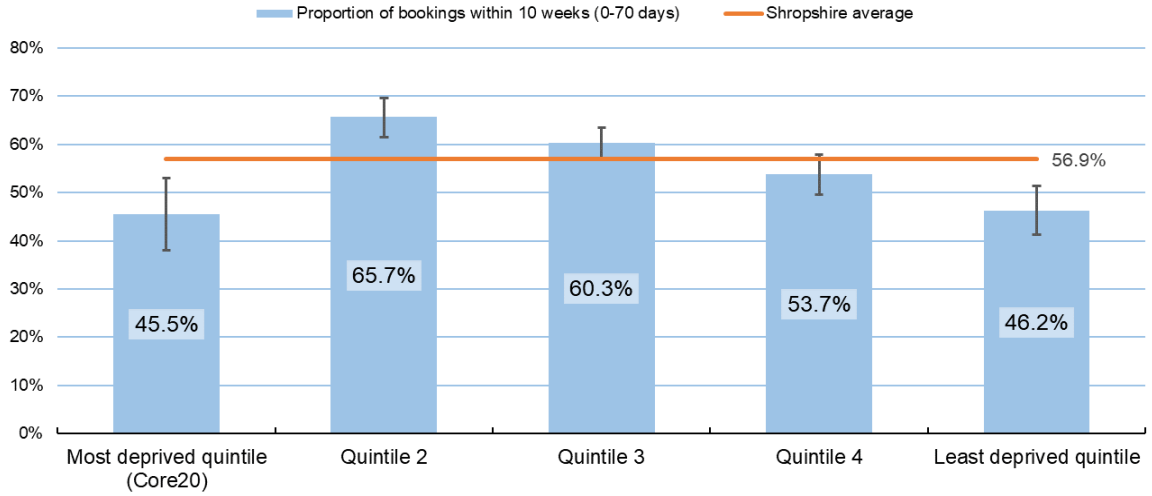
Analysis by ethnicity found that whilst mothers with a White British ethnicity were more likely to be seen in the 10-week target (59%, 1,245) they had a statistically similar rate as mothers from the *White other* (48.3%, 57), *Black or Black British* (46.9%, 15), and *other (*(39.1%, 9) ethnic groupings. However, this could be due to the small number of mothers recorded under these ethnicities. Additionally, 2% (57) of mothers had no ethnicity recorded. It maybe that this analysis needs to be repeated using a longer time frame to get a better understanding of any ethnicity related inequalities.

Proportion of mothers recording their first antenatal appointment within 10-weeks of gestation by mother's ethnicity, 2023-24. Source Maternity Services Data Set (MSDS)



Analysis by social economic status showed that mothers from the least and most deprived neighbourhoods, as per the Index of Multiple Deprivation (IMD2019), were the least likely to have recorded a booking within 10 weeks. With the national health inequality focus being placed on the most deprived communities, it is curious to see that within this cohort of patients, mothers from the most and least deprived neighbourhoods recorded a similar proportion of mothers recording their first antenatal appointment within 10 weeks, with less than 50% of mothers from both communities seen within this time frame. Further work will be required to understand why these two communities are experiencing a similar difficulty with this measure, be it accessibility, transport, cultural or financial.

Proportion of mothers recording their first antenatal appointment within 10-weeks of gestation split by deprivation quintile of the neighbourhood they reside within, 2023-24. Source Maternity Services Data Set (MSDS)



Folic acid supplements taken before pregnancy

Folic acid (also known as vitamin B9) is very important for the development of a healthy foetus, as it can significantly reduce the risk of neural tube defects (NTDs), such as spina bifida. Taking folic acid supplements before pregnancy is important because closure of the neural tube is normally complete by 4 weeks post-conception when many women may not be aware they are pregnant.

All women who could become pregnant are therefore advised to take a daily supplement of folic acid (400 µg) prior to conception and until the 12th week of pregnancy (Department of Health, 1992). Folic acid supplements of 5 mg per day are recommended to prevent the occurrence of neural tube defects in the offspring of men or women with spina bifida themselves or women with a previous pregnancy affected by NTD (Department of Health, 1992). Diabetes UK recommends that all women with diabetes planning a pregnancy should also take a folic acid supplement of 5mg per day.

The child and maternal health profile [19] contains the percentage of pregnant women who started taking folic acid prior to pregnancy as reported at time of their first antenatal appointment, however, there are concerns about the quality of the data. The OHID profile reports these caveats “There is a large range of values and some areas have been suppressed as their values are outliers when compared to the England average. The large range may be affected by the ability of local systems to capture the specific detail needed for

[19] Child and Maternal Health - Data - OHID (phe.org.uk)

this indicator. Some Trusts record this information more effectively than others, not all records have a valid folic acid status and are therefore not covering the whole population cohort. There may be some confusion of the recording as to when the supplement was taken (in preparation for pregnancy or once pregnancy confirmed). In addition, an element of recall and social desirability bias for the pregnant woman may be present." [20]

Although there are concerns about the quality of the data, nevertheless the profile shows that in 2023/24, just 1.5% of women in Shropshire were taking folic acid before pregnancy, which is significantly worse than England (19.7%) and the West Midlands (8%). Shropshire ranked third lowest in the West Midlands region, and lowest among its statistical neighbours with data. There has been a dramatic drop from 30.9% in 2019-20 to 1.5% in 2023-24, compared to the decreases in England (25.7% to 19.7%) and West Midlands (13.5% to 8%).

Percentage taking folic acid supplements before pregnancy in Shropshire, West Midlands and England, 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID

Folic acid supplements taken before pregnancy ⚠ New data 2023/24 — Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	104,895	19.7	19.6	19.8
West Midlands region (statistical)	↓	5,505	8.0	7.8	8.2
Coventry	–	1,010	21.1	19.9	22.2
Solihull	↓	335	15.3	13.8	16.8
Warwickshire	↓	820	12.9	12.1	13.8
Stoke-on-Trent	↓	315	9.1	8.2	10.1
Birmingham	↓	1,170	6.9	6.5	7.3
Sandwell	↓	355	6.5	5.9	7.2
Herefordshire	↓	100	6.1	5.0	7.3
Walsall	↓	225	5.9	5.2	6.6
Worcestershire	→	265	4.9	4.3	5.4
Wolverhampton	↓	145	3.6	3.1	4.3
Shropshire	↓	40	1.5	1.1	2.1
Dudley	–	35	1.0	0.6	1.3
Telford and Wrekin	↓	10	0.5	0.2	0.7
Staffordshire	–	-	*	-	-

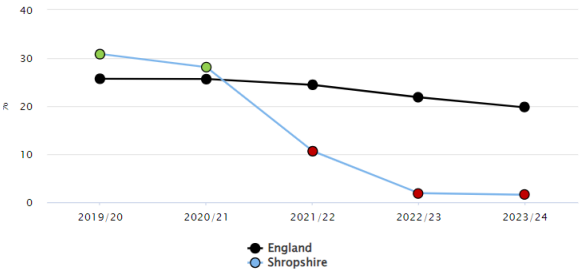
Percentage taking folic acid supplements before pregnancy in Shropshire including nearest statistical neighbours, with England comparison, 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID

Folic acid supplements taken before pregnancy ⚠ 2023/24 — Proportion - %

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↓	-	104,895	19.7	19.6	19.8
Neighbours average	–	-	-	-	-	-
Cornwall	→	11	1,425	33.9*	32.5	35.4
Cheshire East	→	15	1,230	33.7	32.1	35.2
West Berkshire	↓	13	470	32.0	29.7	34.5
Suffolk	↑	8	2,065	31.7	30.6	32.8
Wiltshire	→	2	1,405	29.2	27.9	30.5
East Riding of Yorkshire	↓	6	475	19.0	17.6	20.6
Dorset	↓	12	395	14.3	13.0	15.6
Cumberland	→	7	325	13.0	11.8	14.4
Gloucestershire	↓	9	660	10.4	9.7	11.2
Devon	↓	14	620	9.8	9.1	10.6
North Yorkshire UA	↓	1	485	9.1	8.3	9.9
Somerset UA	↓	4	370	7.2	6.6	8.0
Herefordshire	↓	3	100	6.1	5.0	7.3
Westmorland and Furness	↓	5	55	3.0	2.2	3.8
Shropshire	↓	-	40	1.5	1.1	2.1
Northumberland	–	10	-	*	-	-

[20] Folic acids supplements taken before pregnancy indicator definition

Percentage taking folic acid supplements before pregnancy, with England comparison, 2022-23 to 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID



Recent trend: Decreasing & getting worse

Period		Shropshire Count	Value	95% Lower CI	95% Upper CI	West Midlands	England
2019/20		850	30.9%	29.2%	32.6%	13.5%	25.7%
2020/21		780	28.1%	26.4%	29.8%	13.1%	25.6%
2021/22		280	10.6%	9.5%	11.9%	11.2%	24.4%
2022/23		50	1.9%	1.4%	2.4%	9.4%	21.8%
2023/24		40	1.5%	1.1%	2.1%	8.0%	19.7%

Source: OHID, based on NHS England data

Indicator Definitions and Supporting Information

Smoking in early pregnancy

Modifiable risk factors in pregnancy can have health impacts on both mother and child. At booking appointment midwives will ask questions and perform tests to ascertain these risks and advise on recommended actions.

Smoking during pregnancy causes premature births, miscarriage and perinatal deaths. It also increases the risk of stillbirth, complications in pregnancy, low birthweight, and of the child developing other conditions in later life. The indicator is defined as the percentage of women currently smoking at the time of their maternity booking appointment within the period, with the number of women with a valid smoking status recorded either at booking or at an appointment within the first 14 weeks (98 days) of pregnancy. This was defined as a valid number of cigarettes per day that have been confirmed with the mother at the care contact date or the derived carbon monoxide (CO) monitoring reading from a procedure carried out at the care contact date or the record had a finding code of "smoker" or “non-smoker” which was recorded by the midwife.

There are concerns about the quality of the data for this indicator due to the data collection methods, but it is hoped the recording on systems will improve. However, the profile shows that in 2023/24, in early pregnancy 18.4% of women in Shropshire were known to be smokers, which is significantly worse than the England (13.6%) and the West Midlands (13%). Shropshire ranked second highest in the West Midlands region, significantly above the other areas, and Shropshire’s rate was the second highest among its statistical neighbours. Shropshire’s rate dropped from 21.8% in 2022-23 to 18.4% in 2023-24, compared to the decreases in England (17.2% to 13.6%) and West Midlands (17% to 13%).

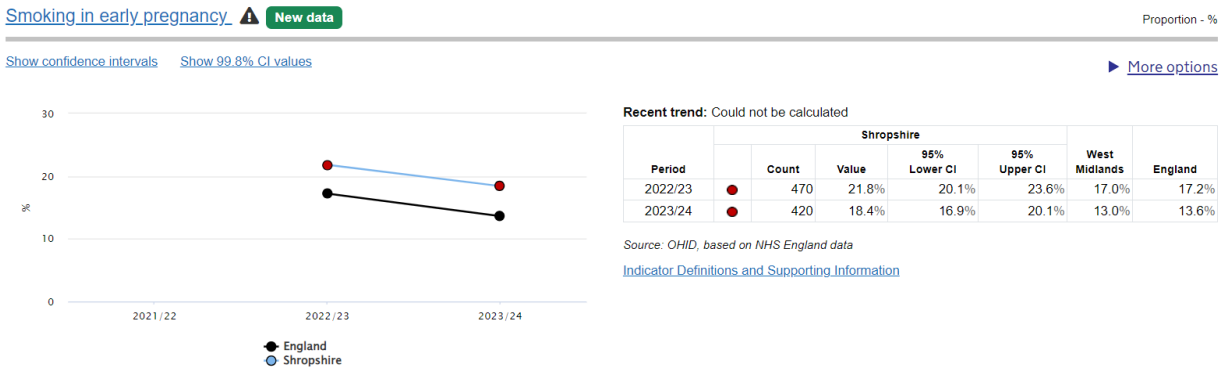
Percentage smoking in early pregnancy in Shropshire including regional neighbours, West Midlands and England, 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	60,725	13.6	13.5	13.7
West Midlands region (statistical)	–	7,080	13.0	12.8	13.3
Telford and Wrekin	–	375	21.2	19.4	23.2
Shropshire	–	420	18.4	16.9	20.1
Stoke-on-Trent	–	455	15.2	14.0	16.5
Worcestershire	–	615	13.3	12.3	14.2
Walsall	–	380	12.2	11.2	13.5
Warwickshire	–	640	11.7	10.9	12.6
Wolverhampton	–	385	11.3	10.3	12.5
Herefordshire	–	165	11.2	9.6	12.9
Coventry	–	415	10.5	9.6	11.5
Birmingham	–	1,390	10.4	9.9	10.9
Solihull	–	200	10.0	8.9	11.5
Dudley	–	-	*	-	-
Sandwell	–	-	*	-	-
Staffordshire	–	-	*	-	-

Percentage smoking in early pregnancy in Shropshire including nearest statistical neighbours and England, 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	60,725	13.6	13.5	13.7
Neighbours average	–	-	-	-	-	-
Somerset UA	–	4	1,070	22.6	21.3	23.7
Shropshire	–	-	420	18.4	16.9	20.1
North Yorkshire UA	–	1	640	15.0	13.9	16.0
Dorset	–	12	380	14.8	13.5	16.2
Gloucestershire	–	9	650	13.9	13.0	15.0
Wiltshire	–	2	540	13.3	12.3	14.3
Cumberland	–	7	280	12.3	11.1	13.8
Herefordshire	–	3	165	11.2	9.6	12.9
East Riding of Yorkshire	–	6	235	10.9	9.6	12.2
West Berkshire	–	13	130	10.3	8.9	12.3
Westmorland and Furness	–	5	160	9.5	8.3	11.1
Cheshire East	–	15	305	9.2	8.2	10.2
Suffolk	–	8	-	*	-	-
Northumberland	–	10	-	*	-	-
Cornwall	–	11	-	*	-	-
Devon	–	14	-	*	-	-

Percentage smoking in early pregnancy in Shropshire, with England comparison, 2022-23 to 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID



Recent trend: Could not be calculated

Period		Shropshire Count	Value	95% Lower CI	95% Upper CI	West Midlands	England
2022/23		470	21.8%	20.1%	23.6%	17.0%	17.2%
2023/24		420	18.4%	16.9%	20.1%	13.0%	13.6%

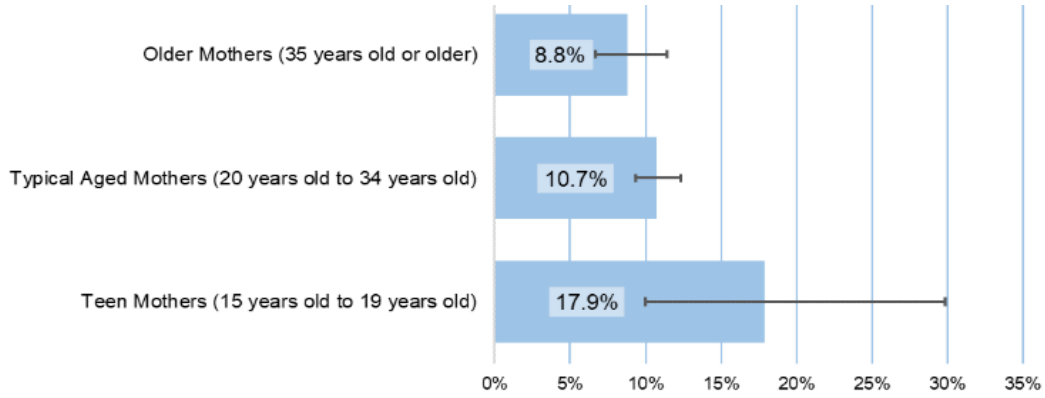
Source: OHID, based on NHS England data

Indicator Definitions and Supporting Information

Local Data

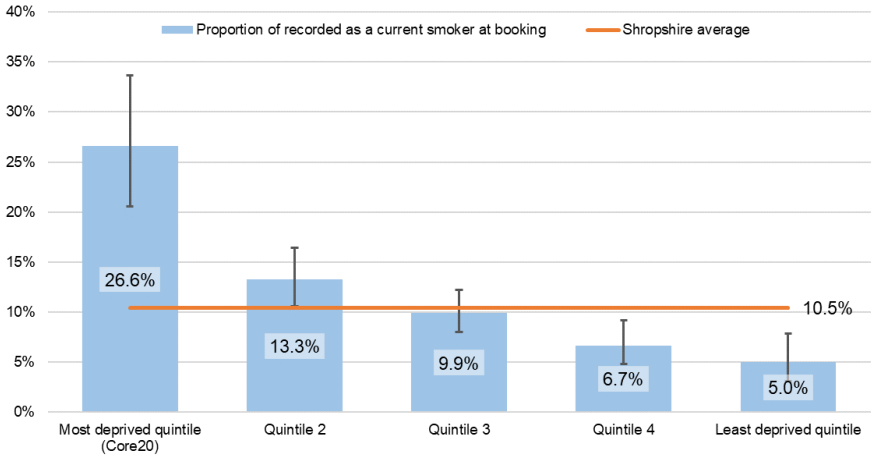
The LMNS maternity dashboard reports that 10.5% of mothers from Shropshire booked onto maternity services during the 2023-24 period were recorded as smokers at the time of their first antenatal booking. There was higher prevalence in the 'White British' group with 11% (225 mothers) and in the 'White other' group with 12% (14 mothers) compared to just 2% (4) of mothers from all other ethnicities. Teen mothers (aged under 20) were identified as having the largest proportion of current smokers at booking (18%,10), statistically, all three age groups examined for this analysis had statistically similar levels of smoking, which could be in part due to the small number of pregnancies recorded among the teen mother's cohort (56) resulting in wide confidence intervals.

Percentage of mothers recorded as being a current smoke at their first antenatal appointment by mothers age at time of booking, 2023-24. Source LMNS dashboard accessed via Aristotle.



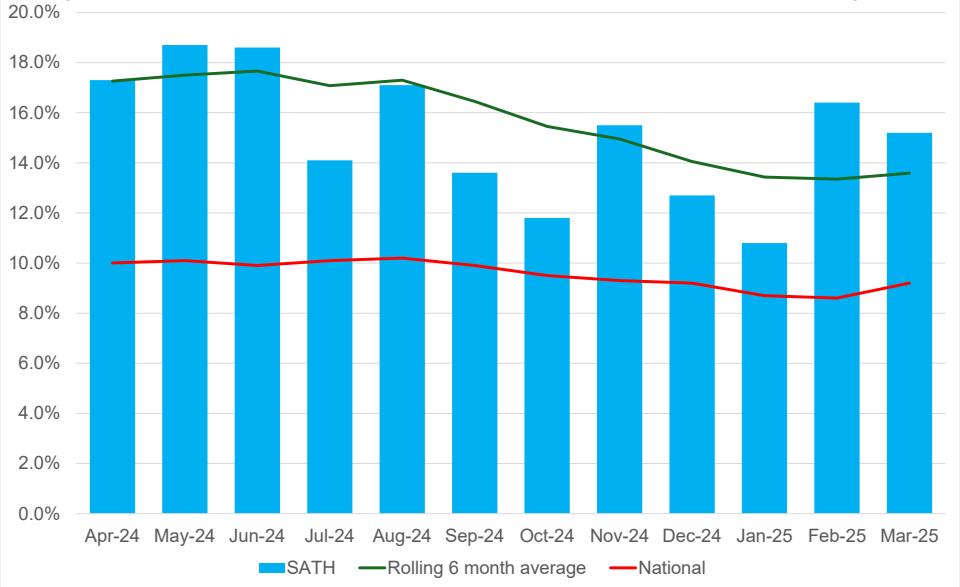
Deprivation continues to be a key driver of tobacco use with 27% (46) of mothers from the most deprived neighbourhoods (IMD2019) recorded as being a smoker at the time of booking, compared to just 5% (17) of mothers from the least deprived neighbourhoods.

Percentage of mothers recorded as being a current smoker at their first antenatal appointment split by deprivation quintile of the neighbourhood they reside within, 2023-24. Source LMNS dashboard accessed via Aristotle



The national maternity dashboard shows that smoking levels of mothers at their booking appointment have been consistently higher every month at The Shrewsbury and Telford Hospital NHS Trust (SATH), compared to nationally in the last year. The peak figure for the trust was 18.7% in May 2024, compared to a peak national figure of 10.2%, although rates have been dropping with the most recent 6 monthly figure in March 2025 being 13.6%, which is still higher than national [21].

Percentage of mothers recorded as being a current smoker at their first antenatal appointment by month, April 2024 to March 2025. Source National maternity dashboard



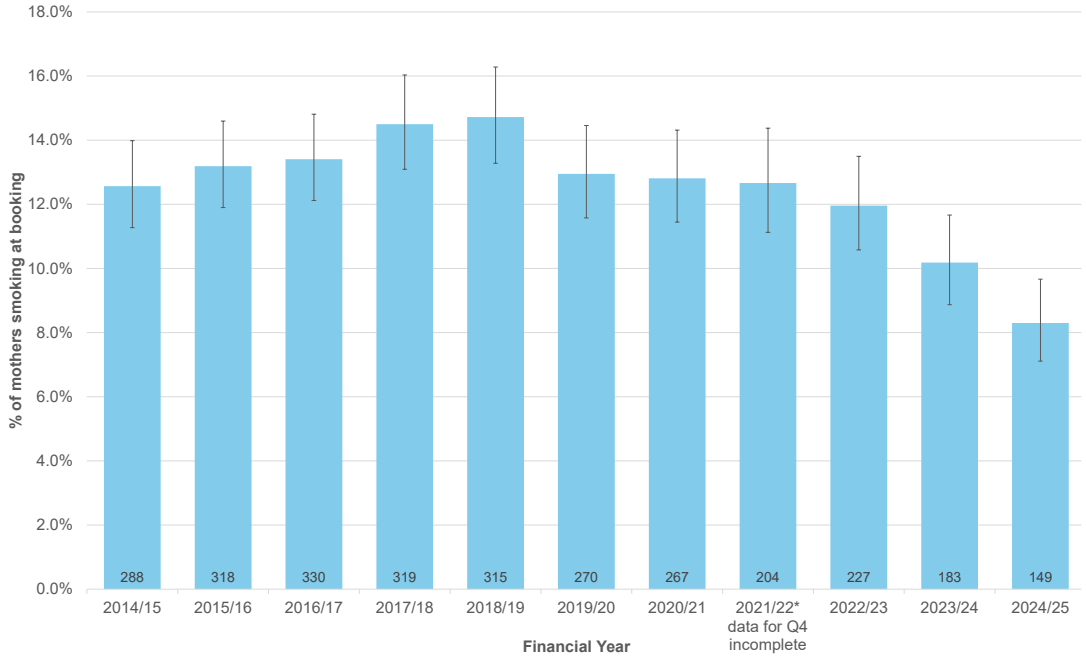
Local data obtained from SATH about births that occurred there when the mother was a resident of Shropshire – this doesn't include those Shropshire mothers who gave birth elsewhere - included retrospective data about their booking appointment which allowed for deeper analysis of mother's smoking status at the booking appointment. There has been a steady decline in smoking levels at booking from 14.7% in 2018-19 to 8.3% in 2024-25 with rates in 2024-25 significantly lower than they were before 2022-23.

The analysis also looked at the three-year period 2022-23 to 2024-25 to provide more robust numbers for analysis. The age group with the highest smoking rates is the 20–24-year-olds (23.5%), and this was significantly higher than older age groups and the figure for Shropshire – the second highest smoking rates were in those less than 20 years old (15.2%), but because there was so few of these, these rates were statistically similar to Shropshire and some of the other groups. Smoking rates in those aged 30 or above with below 10%, with those aged 30-34 and 35-39 significantly below Shropshire's figure.

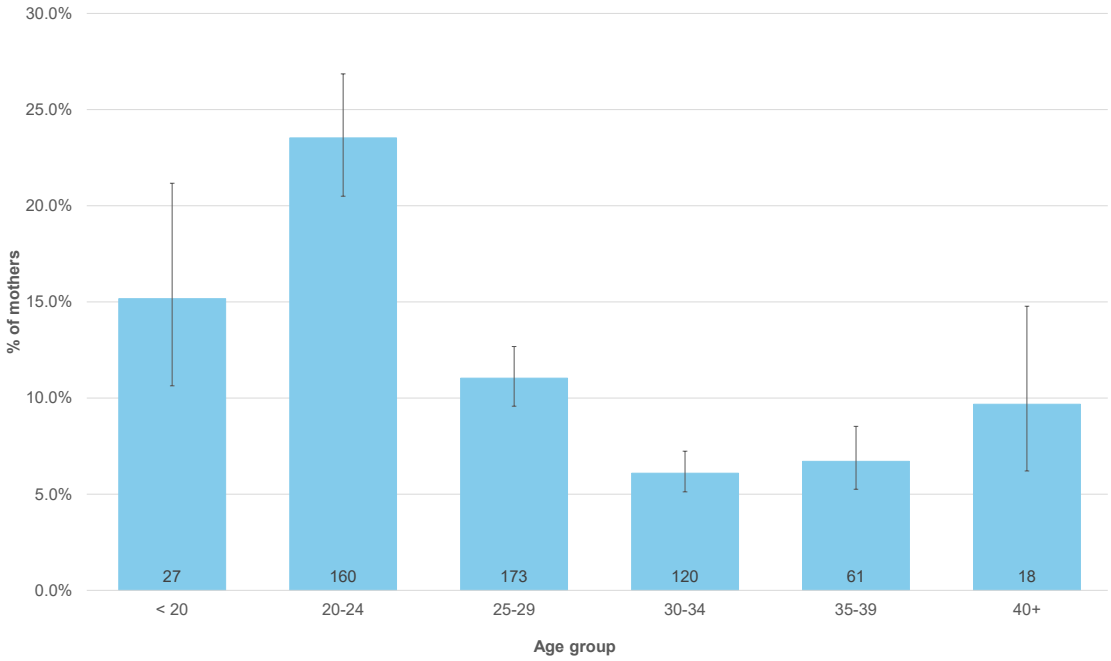
Over a three-year period, analysis shows higher smoking rates in those from more deprived backgrounds – even in the small number of mother's from the most deprived decile, there were 32 smokers which was a prevalence of 36% - significantly more than all but the second most deprived quintile. In total rates were significantly higher than Shropshire in the three most deprived deciles, whilst significantly below Shropshire's in those from deciles 6 to 10.

[21] National Maternity dashboard

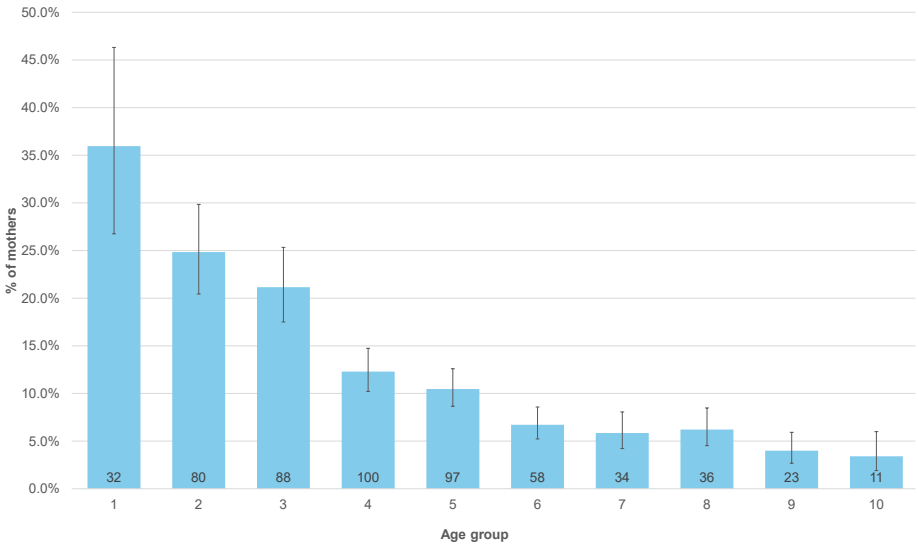
Trends in Mothers smoking at booking appointment for Shropshire mothers who delivered at SATH, 2014-15 to 2024-25. Source: Maternity Database, SATH



Smoking at booking appointment for Shropshire mothers who delivered at SATH by age group, 2022-23 to 2024-25. Source: Maternity Database, SATH



Smoking at booking appointment for Shropshire mothers who delivered at SATH by Shropshire IMD2025 decile, 2022-23 to 2024-25. Source: Maternity Database, SATH



Obesity in early pregnancy

Modifiable risk factors in pregnancy can have health impacts on both mother and child. At booking appointment midwives will ask questions and perform tests to ascertain these risks and advise on recommended actions. Mothers who are overweight or obese have increased risk of complications during pregnancy and birth including diabetes, thromboembolism, miscarriage and maternal death. Babies born to obese women have a higher risk of foetal death, stillbirth, congenital abnormality, shoulder dystocia, macrosomia and subsequent obesity.

The indicator on the child and maternal health profile for obesity in early pregnancy was new for 2024 and is in development, and as such is missing data for a lot of local authorities including Shropshire (hence why they have not been included), however the national figure for 2023-24 was 26.2%, and the West Midlands regional figure was significantly higher at 28.7%. Eleven of Shropshire's statistical neighbours had figures published, with six being significantly above England's.

Percentage of women obese at booking appointment in Shropshire including regional neighbours, West Midlands and England, 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID

Obesity in early pregnancy ⚠ New data 2023/24 Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	-	100,525	26.2	26.1	26.3
West Midlands region (statistical)	-	10,965	28.7	28.3	29.2
Dudley	-	1,070	32.4	30.9	34.1
Wolverhampton	-	925	29.8	28.3	31.5
Worcestershire	-	1,180	27.9	26.6	29.3
Herefordshire	-	345	25.7	23.3	27.9
Solihull	-	465	25.2	23.4	27.3

Percentage of women obese at booking appointment in Shropshire including nearest statistical neighbours and England, 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID

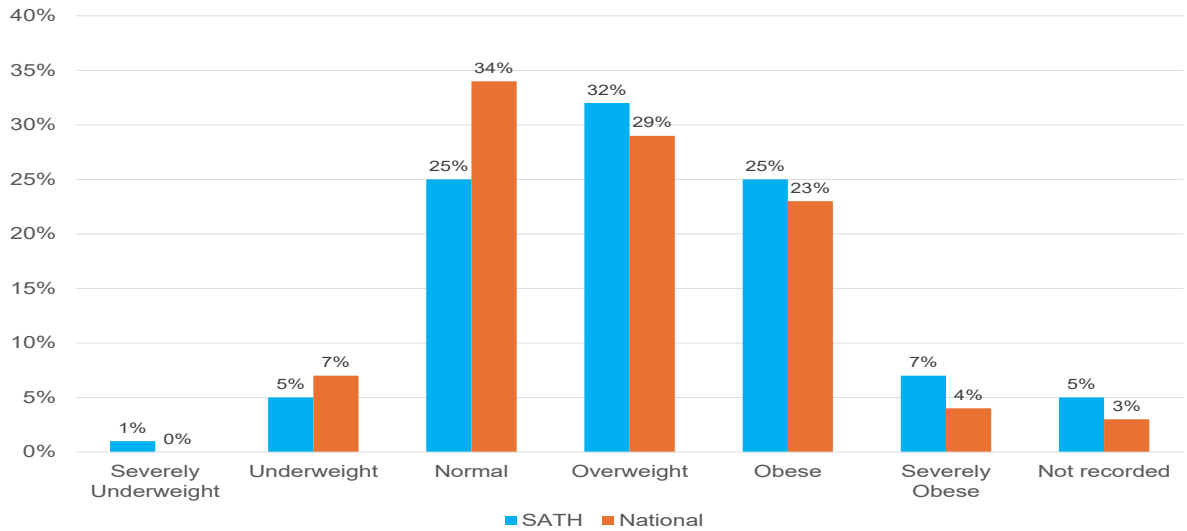
Obesity in early pregnancy ⚠ 2023/24 — Proportion - %

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	100,525	26.2	26.1	26.3
Neighbours average	–	-	-	-	-	-
East Riding of Yorkshire	–	6	625	29.9	27.9	31.8
Cumberland	–	7	645	29.8	28.0	31.8
Somerset UA	–	4	1,130	29.0	27.7	30.5
Cornwall	–	11	1,100	28.9*	27.5	30.4
Wiltshire	–	2	1,135	28.6	27.2	30.1
Dorset	–	12	685	28.6	26.7	30.3
Gloucestershire	–	9	1,500	26.9	25.7	28.0
North Yorkshire UA	–	1	1,100	26.6	25.3	28.0
West Berkshire	–	13	355	26.3	24.1	28.8
Herefordshire	–	3	345	25.7	23.3	27.9
Westmorland and Furness	–	5	385	25.2	23.0	27.3

Local data

Statistics on mothers' weight is not currently being reported by the LMNS dashboard and is not included within the MSDS Maternity Bookings data table. However, there is a national metric called *BMI of Mother at 15 weeks gestation* which is presented in the national MSDS dashboard[22] and in the data from March 2025, a higher percentage of mothers at The Shrewsbury and Telford Hospital NHS Trust were considered a 'obese' (29%) compared to nationally (23%), meanwhile less mothers were 'underweight' – 4% compared to 7%, and the same number were considered of 'normal' weight as national – 33%. However, the numbers fluctuate quite dramatically per month, and in the year 24-25, the percentage of those of 'normal' weight ranged between 30% and 33%, while those 'overweight' ranged between 26% and 32%, and those 'obese' ranged between 23% and 29% respectively.

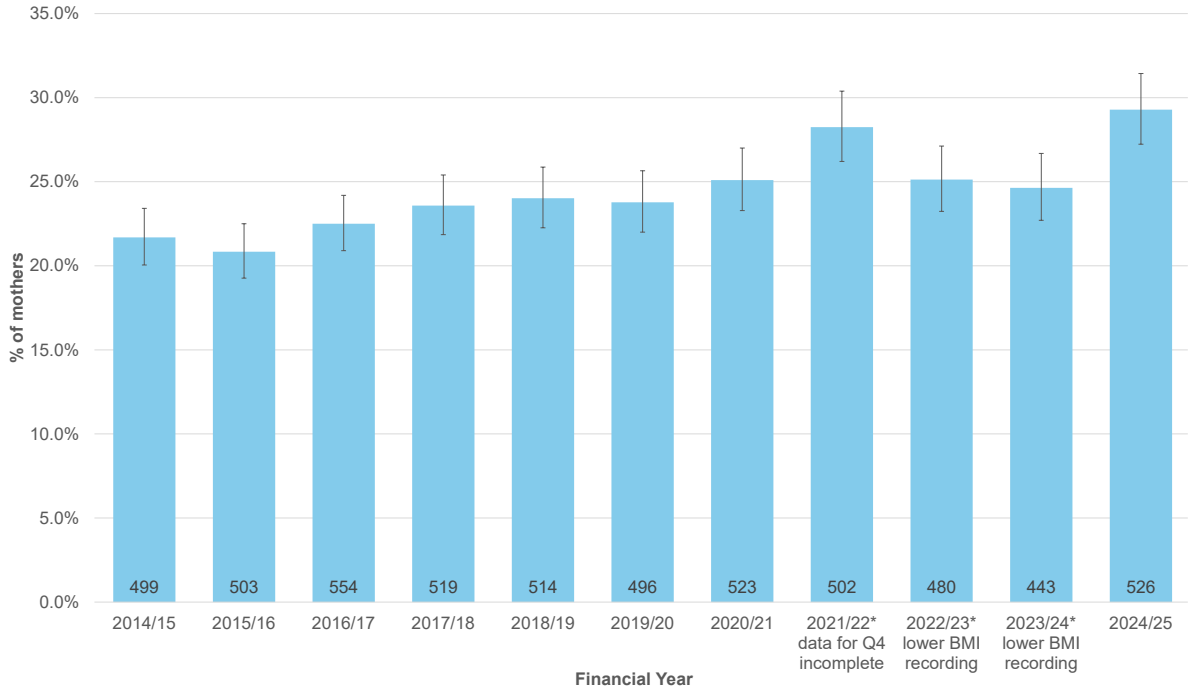
BMI of mother at 15 weeks gestation, Shrewsbury and Telford Hospital compared to the national average, March 2025. Source National maternity dashboard, NHS England



[22] National Maternity dashboard

Local data obtained from SATH about births that occurred there when the mother was resident in Shropshire – this doesn't include those Shropshire mothers who gave birth elsewhere -, included retrospective data about their booking appointment which allowed for deeper analysis, including the mother's BMI at their booking. There has been a steady rise in obesity levels from 21.7% in 2014-15 to 29.3% in 2024-25 with rates in 2024-25 significantly higher than they were before 2020-21 – there was a large number of births in 2022-23 and 2023-24 where BMI was not recorded. This means that although there were over 400 less deliveries in 2024-25 than 2018-19, there were nearly as many mothers who were obese or severely obese at their booking appointment.

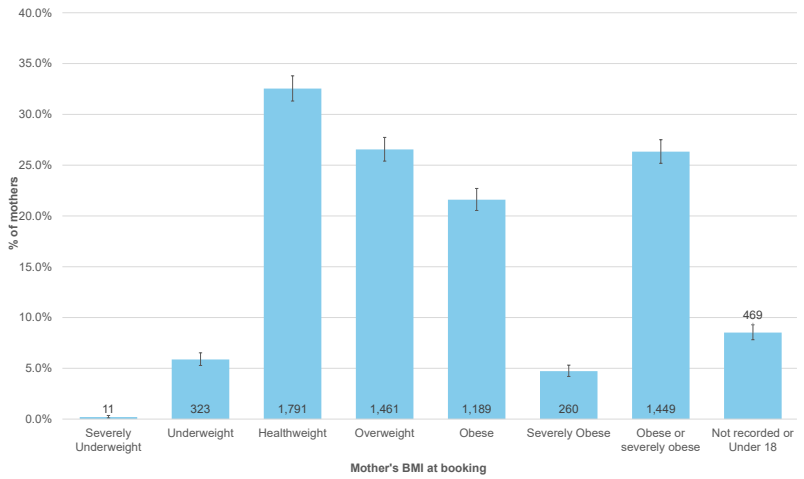
Obesity trends at booking appointment for Shropshire mothers who delivered at SATH, 2014-15 to 2024-25. Source: Maternity Database, SATH



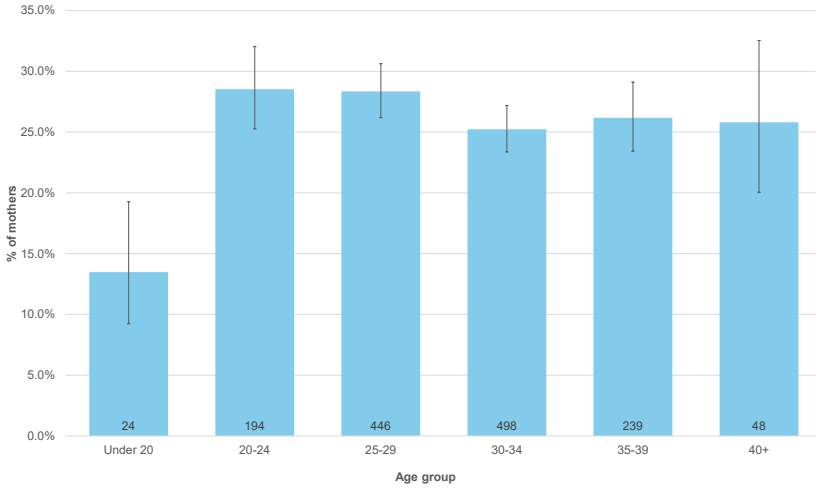
Analysis over a three-year period 2022-23 to 2024-25 showed that 33% of mothers were a healthyweight, 26% were overweight and 22% of mothers were obese, with a further 5% severely obese (BMI 40 or over) – in total 1,449 mothers were either obese or severely obese. These numbers may be greater, as 469 mothers were either under 18 or didn't have their BMI recorded on the computer record. Overall obesity was just 13.5% in the under 20 age group (excludes those under 18), which was significantly lower than other age groups, but rose to 28.5% among 20–24-year-olds and to 28.4% in the 25-29 age group, whilst being slightly lower in older age, but not significantly lower.

The lowest obesity levels were in those from those from the least deprived decile (17.3%), which was significantly lower than the total for Shropshire (26.3%), but the second lowest was in those from the most deprived decile (22.5%) which was not significantly higher. Obesity levels were at the highest from those in the third most deprived decile (32%), the only decile significantly above Shropshire.

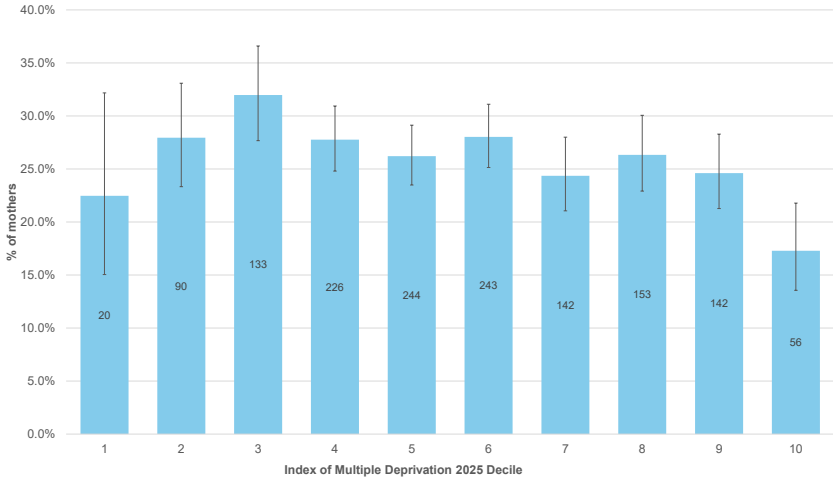
BMI at booking appointment for Shropshire mothers who delivered at SATH, 2022-23 to 2024-25. Source: Maternity Database, SATH



Obesity at booking appointment for Shropshire mothers who delivered at SATH by age group, 2022-23 to 2024-25. Source: Maternity Database, SATH



Obesity at booking appointment for Shropshire mothers who delivered at SATH by IMD2025 decile, 2022-23 to 2024-25. Source: Maternity Database, SATH



Smoking status at time of delivery

Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. On average, smokers have more complications during pregnancy and labour, including bleeding during pregnancy, placental abruption and premature rupture of membranes.

Encouraging pregnant women to stop smoking during pregnancy may also help them kick the habit for good, and thus provide health benefits for the mother and reduce exposure to second-hand smoke by the infant. Smoking during pregnancy can cause serious pregnancy-related health problems. These include complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birthweight and sudden unexpected death in infancy. The Tobacco Control Plan contains a national ambition to reduce the rate of smoking throughout pregnancy to 6% or less by the end of 2022 (measured at time of giving birth). The inclusion of this indicator will ensure that the local tobacco control activity is appropriately focused on pregnant women, in order to try to achieve this national ambition. Inclusion of this indicator will also encourage the continued prioritisation of action to reduce smoking at delivery. Decreases in smoking during pregnancy will result in health benefits for the infant and mother, as well as cost savings to the NHS.

In the period 2024-25, 7.1% of women in Shropshire were known to be smokers at the time of delivery, which is higher, but not significantly higher than the West Midlands (6.2%) and England (6.1%). Shropshire currently ranks fifth highest in the West Midlands region (3rd highest last year) and has dropped to fourth highest among its statistical neighbours, from highest in 2023-24. The trends show that Shropshire has always been above England's rate going back to 2010-11 although for the first time since 2019-20 has dropped to being higher than England, but not significantly higher, and has now dropped to its lowest rate.

Percentage of women known to be smokers at the time of delivery in Shropshire with West Midlands and England comparisons, 2024-25. Source: Child and Maternal Health Profile, Fingertips, OHID

Smoking status at time of delivery 2024/25 — Proportion - %

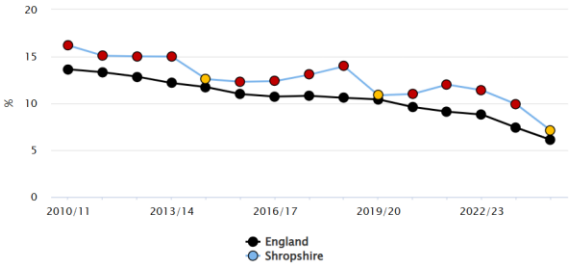
Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	31,670	6.1	6.0	6.2
West Midlands region (statistical)	↓	3,790	6.2	6.1	6.4
Stoke-on-Trent	↓	233	7.6	6.7	8.6
Wolverhampton	↓	233	7.1	6.2	8.0
Walsall	↓	229	7.1	6.2	8.0
Telford and Wrekin	↓	130	7.1	6.0	8.3
Shropshire	↓	164	7.1	6.1	8.2
Sandwell	↓	298	7.1	6.3	7.9
Dudley	→	228	7.1	6.2	8.0
Worcestershire	↓	303	6.3	5.7	7.1
Herefordshire	↓	87	6.3	5.1	7.7
Staffordshire	↓	440	6.1	5.6	6.7
Warwickshire	↓	296	5.8	5.2	6.5
Coventry	↓	209	5.8	5.1	6.6
Solihull	↓	112	5.4	4.5	6.4
Birmingham	↓	828	5.4	5.0	5.8

Percentage of women known to be smokers at the time of delivery in Shropshire with nearest statistical neighbours and England comparisons, 2024-25. Source: Child and Maternal Health Profile, Fingertips, OHID

Smoking status at time of delivery 2024/25 — Proportion - %

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↓	-	31,670	6.1	6.0	6.2
Neighbours average	–	-	-	-	-	-
Wiltshire	→	2	365	9.7*	8.8	10.7
Cornwall	↓	11	301	8.7*	7.8	9.7
Somerset UA	–	4	340	7.5	6.8	8.3
Shropshire	↓	-	164	7.1	6.1	8.2
Gloucestershire	↓	9	388	6.9	6.3	7.6
Westmorland and Furness	–	5	105	6.9*	5.8	8.3
East Riding of Yorkshire	↓	6	151	6.7	5.7	7.8
Devon	↓	14	241	6.4*	5.7	7.3
Cumberland	–	7	125	6.3*	5.3	7.4
Herefordshire	↓	3	87	6.3	5.1	7.7
Northumberland	↓	10	131	6.0	5.1	7.1
North Yorkshire UA	–	1	294	5.6	5.0	6.2
Dorset	↓	12	115	5.4	4.5	6.5
Suffolk	↓	8	306	4.9	4.4	5.5
Cheshire East	↓	15	149	4.8	4.1	5.6
West Berkshire	→	13	58	4.3	3.3	5.5

Percentage of women known to be smokers at the time of delivery in Shropshire with England comparisons, 2010-11 to 2024-25. Source: Child and Maternal Health Profile, Fingertips, OHID



Recent trend: ↓ Decreasing & getting better

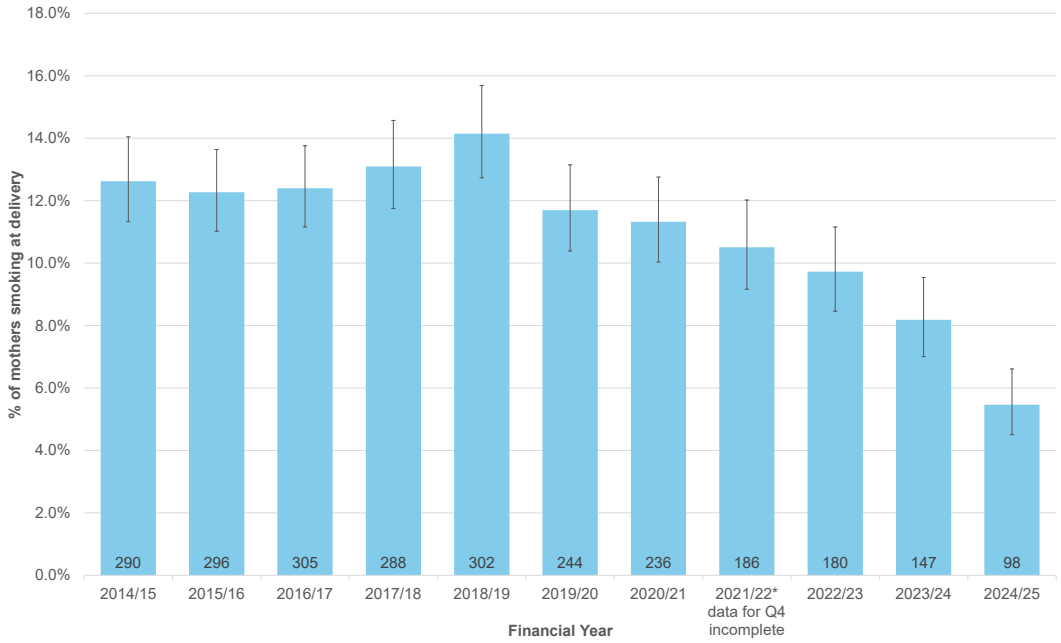
Period		Shropshire Count	Shropshire Value	Shropshire 95% Lower CI	Shropshire 95% Upper CI	West Midlands	England
2010/11	●	405	16.2%	14.8%	17.7%	16.0%	13.6%
2011/12	●	372	15.1%	13.7%	16.6%	15.6%	13.3%
2012/13	●	379	15.0%	13.7%	16.5%	14.4%	12.8%
2013/14	●	364	15.0%	13.6%	16.5%	13.3%	12.2%
2014/15	○	289	12.6%	11.3%	14.0%	12.9%*	11.7%
2015/16	●	297	12.3%	11.0%	13.7%	11.9%*	11.0%
2016/17	●	305	12.4%	11.1%	13.7%	11.8%	10.7%
2017/18	●	289	13.1%	11.7%	14.5%	11.9%	10.8%
2018/19	●	347	14.0%	12.6%	15.4%	11.9%*	10.6%
2019/20	○	273	10.9%	9.7%	12.1%	12.1%*	10.4%
2020/21	●	264	11.0%	9.9%	12.4%	10.6%	9.6%
2021/22	●	308	12.0%	10.8%	13.3%	9.8%	9.1%
2022/23	●	283	11.4%	10.3%	12.8%	9.1%	8.8%
2023/24	●	231	9.9%	8.7%	11.2%	7.8%	7.4%
2024/25	○	164	7.1%	6.1%	8.2%	6.2%	6.1%

Local data

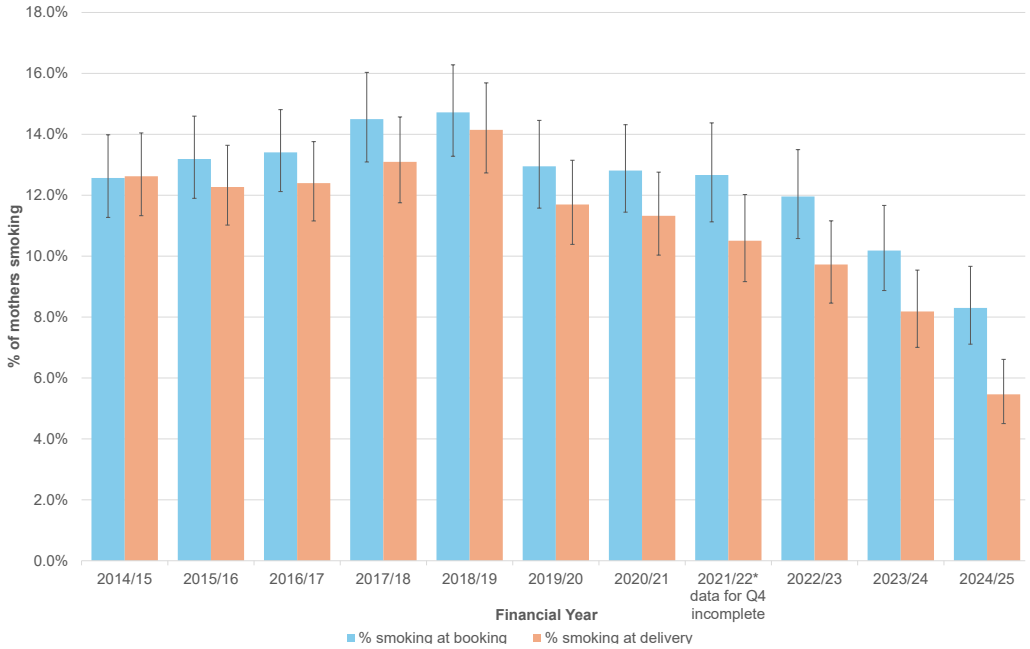
Local data obtained from SATH about births that occurred there when the mother was a Shropshire resident (so not including those that gave birth elsewhere), included retrospective data about their booking appointment which allowed for deeper analysis.

There had been a steady rise in smoking at delivery levels from 2014-15 to a high of 14.1% in 2018-19, but in the years since the rates have come down, with the most recent period of 2024-25 showing a rate of 5.5% - which is a significantly lower figure - in this period the number of smokers at time of delivery has fallen from 302 to just 98. Every year there has been a drop this cohort of mothers smoking from their booking appointment to delivery - in 2024-25 the drop was 8.3% to 5.5% (58 women were smokers at booking but were non-smokers by delivery).

Smoking at the time of delivery for Shropshire mothers who delivered at SATH, 2014-15 to 2024-25. Source: Maternity Database, Shrewsbury and Telford Hospital NHS Trust

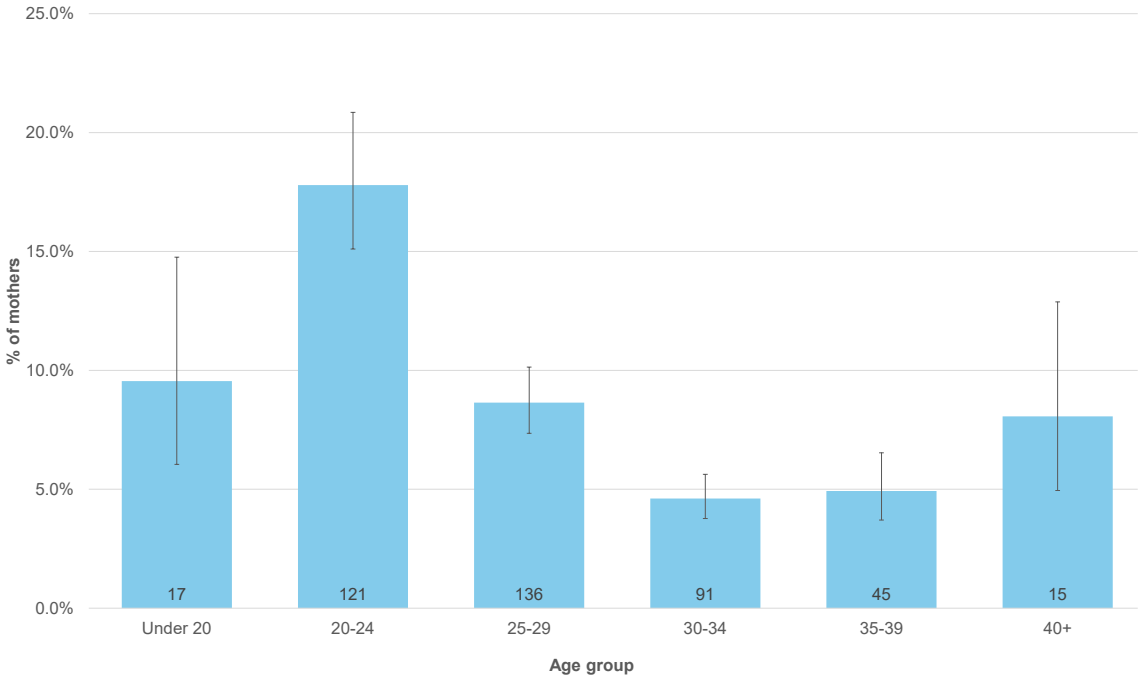


Smoking at booking vs at delivery for Shropshire mothers who delivered at SATH, 2014-15 to 2024-25. Source: Maternity Database, Shrewsbury and Telford Hospital NHS Trust

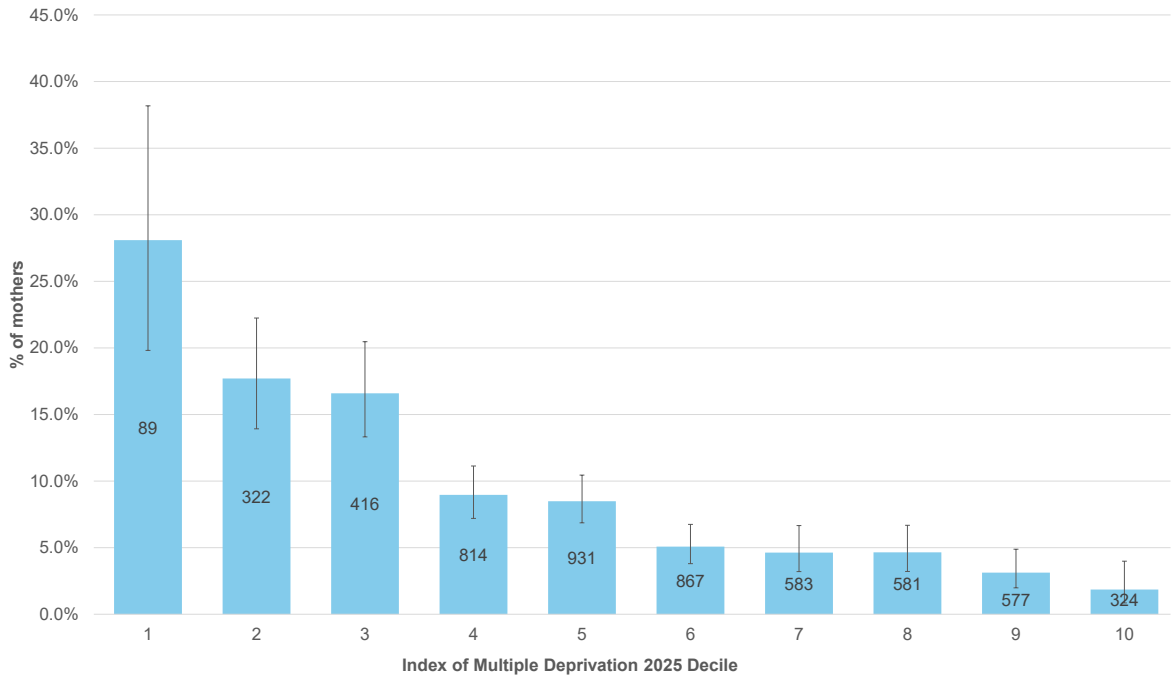


In the three-year period 2022-23 to 2024-25, there were a total of 425 smokers at delivery. Smoking rates were significantly higher than other age groups in those in the 20-24 age group (17.8%, 121 smokers), while rates in those aged 30-34 and 35-39 were significantly lower than the Shropshire average (4.6% and 4.9% respectively). There are significantly higher smoking levels in the three most deprived deciles, while rates in the least 5 deciles were significantly below the Shropshire average.

Smoking at delivery for Shropshire mothers who delivered at SATH by age group, 2022-23 to 2024-25. Source: Maternity Database, Shrewsbury and Telford Hospital NHS Trust



Smoking delivery for Shropshire mothers who delivered at SATH by IMD2025 decile, 2022-23 to 2024-25. Source: Maternity Database, Shrewsbury and Telford Hospital NHS Trust



Stillbirth rate

Stillbirth rates in the United Kingdom have shown little change over the last 20 years, and the rate remains among the highest in high income countries[23]. Risk factors associated with stillbirth include maternal obesity, ethnicity, smoking, pre-existing diabetes, and history of mental health problems, antepartum haemorrhage and fetal growth restriction (birth weight below the 10th customised weight percentile)[30]. In 2015 the government announced an ambition to halve the rate of stillbirths by 2030[30].

In the period 2022-24, there were 20 stillbirths (fetal deaths occurring after 24 weeks of gestation) in Shropshire[24]. This equates to a rate of 2.7 per 1,000 births. This rate was the second lowest regionally, but not significantly lower than the regional rate of 4.4 per 1,000 and the national rate of 3.9 per 1,000[31]. Shropshire's rate was statistically similar to all of its statistical neighbours as shown in the figure below.

Stillbirth rate per 1,000 births in Shropshire, including regional neighbours, West Midlands and England, 2022-24. Source: Child and Maternal Health Profile, Fingertips, OHID

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	6,688	3.9	3.8	4.0
West Midlands region (statistical)	–	841	4.4	4.1	4.7
Sandwell	–	93	6.9	5.6	8.5
Coventry	–	69	5.6	4.4	7.1
Birmingham	–	247	5.5	4.9	6.3
Wolverhampton	–	52	5.1	3.8	6.7
Walsall	–	49	4.7	3.5	6.2
Dudley	–	45	4.4	3.2	5.9
Stoke-on-Trent	–	40	4.4	3.1	5.9
Herefordshire	–	17	3.7*	2.2	6.0
Telford and Wrekin	–	21	3.6	2.2	5.5
Staffordshire	–	81	3.4	2.7	4.3
Worcestershire	–	46	2.9	2.1	3.9
Warwickshire	–	48	2.8	2.0	3.7
Shropshire	–	20	2.7	1.6	4.2
Solihull	–	13	2.2*	1.2	3.8

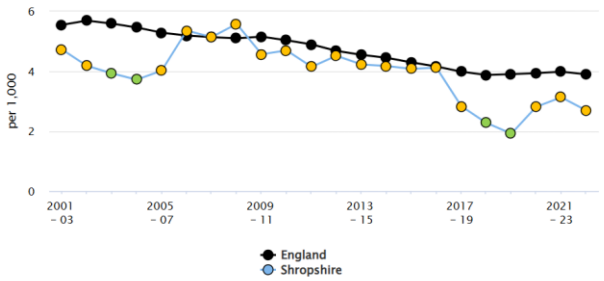
Stillbirth rate per 1,000 births in Shropshire, including statistical neighbours, with England comparison, 2022-24. Source: Child and Maternal Health Profile, Fingertips, OHID

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	6,688	3.9	3.8	4.0
Neighbours average	–	-	-	-	-	-
Cheshire East	–	15	49	4.5	3.3	5.9
Suffolk	–	8	86	4.3	3.4	5.3
Cumberland	–	7	28	4.1	2.7	5.9
Herefordshire	–	3	17	3.7*	2.2	6.0
Gloucestershire	–	9	62	3.5	2.7	4.5
Northumberland	–	10	25	3.4	2.2	5.0
Devon	–	14	60	3.3	2.5	4.3
Dorset	–	12	24	3.2	2.0	4.7
Cornwall	–	11	40	3.1*	2.2	4.2
North Yorkshire UA	–	1	45	3.1	2.3	4.1
Somerset UA	–	4	43	3.0	2.2	4.1
Wiltshire	–	2	39	3.0	2.1	4.1
Shropshire	–	-	20	2.7	1.6	4.2
West Berkshire	–	13	11	2.6*	1.3	4.6
Westmorland and Furness	–	5	12	2.4*	1.3	4.3
East Riding of Yorkshire	–	6	13	1.7*	0.9	2.9

[23] Child and Maternal Health - Data - OHID (phe.org.uk)
[24] Child and Maternal Health - Data - OHID (phe.org.uk)

As shown in the figure below, Shropshire's stillbirth rate has decreased since 2010-12, with the rate particularly dropping from 2016-18 to 2017-19, but slightly increased since. The rates have been statistically similar to England, apart from in 2018-20 and 2019-21 when they were significantly below England's.

Stillbirth rate in Shropshire, including West Midlands and England comparisons, 2010-12 to 2022-24. Source: Child and Maternal Health Profile, Fingertips, OHID



Recent trend: Could not be calculated

Period		Shropshire Count	Value	95% Lower CI	95% Upper CI	Neighbrs average	England
2001 - 03		39	4.7	3.4	6.5	-	5.6
2002 - 04		35	4.2	2.9	5.8	-	5.7
2003 - 05		33	3.9	2.7	5.5	-	5.6
2004 - 06		31	3.7	2.5	5.3	-	5.5
2005 - 07		34	4.0	2.8	5.6	-	5.3
2006 - 08		46	5.4	3.9	7.1	-	5.2
2007 - 09		45	5.1	3.8	6.9	-	5.1
2008 - 10		49	5.6	4.1	7.4	-	5.1
2009 - 11		40	4.6	3.3	6.2	-	5.2
2010 - 12		41	4.7	3.4	6.4	-	5.0
2011 - 13		36	4.2	2.9	5.7	-	4.9
2012 - 14		39	4.5	3.2	6.2	-	4.7
2013 - 15		36	4.2	3.0	5.9	-	4.6
2014 - 16		36	4.2	2.9	5.8	-	4.5
2015 - 17		35	4.1	2.8	5.7	-	4.3
2016 - 18		35	4.1	2.9	5.7	-	4.2
2017 - 19		23	2.8	1.8	4.3	-	4.0
2018 - 20		18	2.3*	1.4	3.6	-	3.9
2019 - 21		15	1.9*	1.1	3.2	-	3.9
2020 - 22		22	2.8	1.8	4.3	-	3.9
2021 - 23		24	3.1	2.0	4.7	-	4.0
2022 - 24		20	2.7	1.6	4.2	-	3.9

Low birth weight of all babies

Low birthweight is an enduring aspect of childhood morbidity, a major factor in infant mortality and has serious consequences for health in later life (NICE). There are social inequalities in low birthweight in England and Wales and these inequalities are likely to affect childhood and adult health inequalities in the future, hence strategies will need to address differences in low birthweight and further monitoring of trends is therefore desirable.

This is defined as all births (live and still births) with a recorded birth weight under 2500g as a percentage of all live births with stated birth weight. In 2023, of all babies, 6.1% (148) were found to be of low birth weight which is statistically lower than England (7.4%) and was the lowest in the region and significantly below the West Midlands average (8.1%) and was statistically similar all of its nearest statistical neighbours (6th lowest). Shropshire has been lower than England every year between 2010 and 2023, although sometimes statistically similar, and sometimes significantly lower.

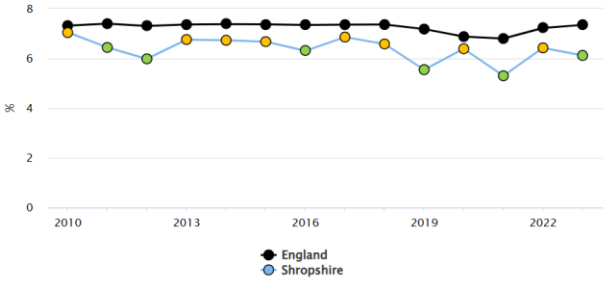
Percentage of low of birth weight of babies in Shropshire, regional neighbours, West Midlands and England, 2023. Source: Child and Maternal Health Profile, Fingertips, OHID

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	⬆	40,405	7.4	7.3	7.4
West Midlands region (statistical)	⬇	5,006	8.1	7.9	8.3
Wolverhampton	➡	332	9.7	8.8	10.8
Sandwell	➡	418	9.6	8.7	10.5
Birmingham	➡	1,363	9.5	9.1	10.0
Walsall	➡	315	9.4	8.5	10.4
Dudley	➡	279	8.3	7.5	9.3
Solihull	➡	155	8.0	6.9	9.3
Coventry	➡	310	7.9	7.1	8.8
Telford and Wrekin	➡	138	7.2	6.2	8.5
Worcestershire	➡	371	7.1	6.5	7.9
Stoke-on-Trent	⬇	194	6.9	6.0	7.8
Warwickshire	➡	381	6.7	6.1	7.4
Herefordshire	➡	100	6.7	5.5	8.1
Staffordshire	➡	502	6.6	6.1	7.2
Shropshire	➡	148	6.1	5.2	7.1

Percentage of low of birth weight of babies in Shropshire, including statistical neighbours, and England, 2023. Source: Child and Maternal Health Profile, Fingertips, OHID

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	⬆	40,405	7.4	7.3	7.4
West Midlands region (statistical)	⬇	5,006	8.1	7.9	8.3
Wolverhampton	➡	332	9.7	8.8	10.8
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Percentage of low of birth weight babies in Shropshire, West Midlands and England comparisons, 2010–23. Source: Child and Maternal Health Profile, Fingertips, OHID



Recent trend: ➡ No significant change

Period		Shropshire Count	Value	95% Lower CI	95% Upper CI	Neighbrs average	England
2010	🟡	204	7.1%	6.2%	8.0%	6.4%*	7.3%
2011	🟢	186	6.4%	5.6%	7.4%	6.2%*	7.4%
2012	🟢	174	6.0%	5.2%	6.9%	6.4%*	7.3%
2013	🟡	191	6.8%	5.9%	7.7%	6.5%*	7.4%
2014	🟡	190	6.7%	5.9%	7.7%	6.5%*	7.4%
2015	🟡	187	6.7%	5.8%	7.7%	6.4%*	7.4%
2016	🟢	186	6.3%	5.5%	7.2%	6.6%*	7.3%
2017	🟡	192	6.9%	6.0%	7.9%	6.5%*	7.4%
2018	🟡	179	6.6%	5.7%	7.6%	6.6%*	7.4%
2019	🟢	143	5.5%	4.7%	6.5%	6.1%*	7.2%
2020	🟡	164	6.4%	5.5%	7.4%	5.9%*	6.9%
2021	🟢	140	5.3%	4.5%	6.2%	5.9%*	6.8%
2022	🟡	165	6.4%	5.5%	7.4%	6.3%*	7.2%
2023	🟢	148	6.1%	5.2%	7.1%	6.3%*	7.4%

Very low birth weight of all babies

Low birthweight is an enduring aspect of childhood morbidity, a major factor in infant mortality and has serious consequences for health in later life (NICE). There are social inequalities in low birthweight in England and Wales and these inequalities are likely to affect childhood and adult health inequalities in the future, hence strategies will need to address differences in low birthweight and further monitoring of trends is therefore desirable.

This is defined as all births (live and still births) with a recorded birth weight under 1500g as a percentage of all live births with stated birth weight. In 2023, of all babies, 0.7% (16 babies) were found to be of very low birth weight which is similar to England (1.1%) but is significantly lower than the West Midlands average (1.3%) and is the second lowest in the West Midlands. Shropshire's rate is similar to all of its nearest statistical neighbours. Shropshire's percentage for very low birth weight babies has been statistically similar to England's between 2011 and 2023, besides 2019 when it was significantly lower.

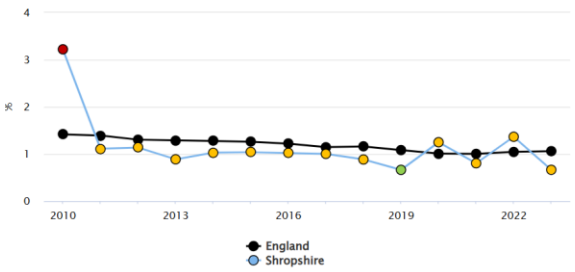
Percentage of very low of birth weight of babies in Shropshire, regional neighbours, West Midlands and England, 2023. Source: Child and Maternal Health Profile, Fingertips, OHID

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	5,812	1.1	1.0	1.1
West Midlands region (statistical)	→	799	1.3	1.2	1.4
Birmingham	→	259	1.8	1.6	2.0
Sandwell	→	79	1.8	1.5	2.2
Wolverhampton	→	50	1.5	1.1	1.9
Walsall	→	48	1.4	1.1	1.9
Herefordshire	→	19	1.3	0.8	2.0
Solihull	→	24	1.2	0.8	1.8
Telford and Wrekin	→	23	1.2	0.8	1.8
Dudley	→	40	1.2	0.9	1.6
Coventry	↓	44	1.1	0.8	1.5
Staffordshire	→	85	1.1	0.9	1.4
Worcestershire	→	51	1.0	0.7	1.3
Warwickshire	→	43	0.8	0.6	1.0
Shropshire	→	16	0.7	0.4	1.1
Stoke-on-Trent	→	18	0.6	0.4	1.0

Percentage of very low of birth weight of babies in Shropshire, statistical neighbours and England, 2023. Source: Child and Maternal Health Profile, Fingertips, OHID

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	→	-	5,812	1.1	1.0	1.1
Neighbours average	–	-	476	0.9*	0.8	0.9
Herefordshire	→	3	19	1.3	0.8	2.0
North Yorkshire UA	→	1	58	1.2	0.9	1.6
Cheshire East	→	15	40	1.1	0.8	1.5
Dorset	→	12	25	1.1	0.7	1.6
Suffolk	→	8	57	0.9	0.7	1.2
Devon	→	14	53	0.9	0.7	1.2
Gloucestershire	→	9	48	0.8	0.6	1.1
Wiltshire	→	2	34	0.8	0.6	1.1
Cumberland	–	7	18	0.8	0.5	1.3
East Riding of Yorkshire	→	6	20	0.8	0.5	1.2
Somerset UA	→	4	34	0.7	0.5	1.0
Shropshire	→	-	16	0.7	0.4	1.1
Northumberland	→	10	15	0.6	0.4	1.0
Cornwall	→	11	24	0.6*	0.4	0.9
Westmorland and Furness	–	5	9	0.6	0.3	1.0
West Berkshire	→	13	6	0.4	0.2	1.0

Percentage of very low of birth weight babies in Shropshire, including West Midlands and England, 2010–23. Source: Child and Maternal Health Profile, Fingertips, OHID



Recent trend: ➡ No significant change

Period		Shropshire Count	Value	95% Lower CI	95% Upper CI	West Midlands	England
2010		93	3.2%	2.6%	3.9%	1.7%	1.4%
2011		32	1.1%	0.8%	1.6%	1.6%	1.4%
2012		33	1.1%	0.8%	1.6%	1.4%	1.3%
2013		25	0.9%	0.6%	1.3%	1.4%	1.3%
2014		29	1.0%	0.7%	1.5%	1.5%	1.3%
2015		29	1.0%	0.7%	1.5%	1.7%	1.3%
2016		30	1.0%	0.7%	1.4%	1.7%	1.2%
2017		28	1.0%	0.7%	1.4%	1.5%	1.1%
2018		24	0.9%	0.6%	1.3%	1.6%	1.2%
2019		17	0.7%	0.4%	1.1%	1.4%	1.1%
2020		32	1.2%	0.9%	1.8%	1.4%	1.0%
2021		20	0.8%	0.5%	1.2%	1.4%	1.0%
2022		35	1.4%	1.0%	1.9%	1.3%	1.0%
2023		16	0.7%	0.4%	1.1%	1.3%	1.1%

Deliveries by Caesarean section %

Caesarean sections are often required for a number of maternal and infant reasons. By their very nature (i.e. they are used when there are complications) they are likely to be associated with an increased risk of problems. This looks at the percentage of deliveries by caesarean section.

In 2023-24, Shropshire had a caesarean section figure 41.4%, which would make it slightly higher but statistically similar to England (40.9%) and the West Midlands (40.2%), which would be the second highest figure in the region and the fifth highest among nearest statistical neighbours, however, there appears to be a data quality issue with this figure for this year as there was in 22-23, with OHID stating that HES maternity data was not fully completed by Shrewsbury and Telford Hospital NHS Trust. The trends data shows that the figure for Shropshire had previously been significantly below England's and the West Midlands for every year going back to 2013-14, with Shropshire's figure in 2022-23 being 36.4%, compared to 37.6% in the West Midlands and 37.8% for England.

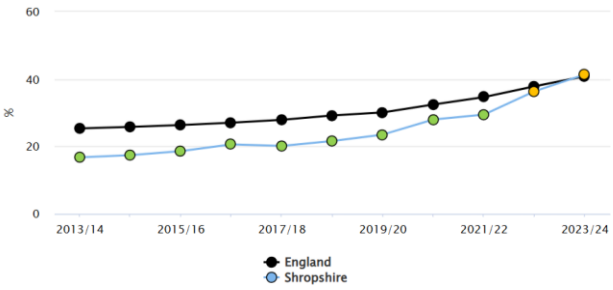
Percentage of caesarean sections in Shropshire, regional neighbours, West Midlands and England, 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	⬆	209,753	40.9	40.7	41.0
West Midlands region (statistical)	⬆	22,195	40.2	39.8	40.7
Herefordshire	⬆	660	45.5	43.0	48.2
Solihull	⬆	790	43.2	41.0	45.6
Walsall	⬆	1,245	42.7	40.9	44.4
Staffordshire	⬆	2,965	41.9	40.8	43.1
Shropshire	⬆	120	41.4*	36.7	48.0
Wolverhampton	⬆	1,330	40.7	39.1	42.5
Stoke-on-Trent	⬆	1,185	40.7	38.9	42.5
Dudley	⬆	1,285	40.5	38.9	42.3
Warwickshire	⬆	2,110	40.2	38.9	41.5
Birmingham	⬆	5,605	39.5	38.7	40.3
Sandwell	⬆	1,605	39.1	37.6	40.6
Coventry	⬆	1,495	38.0	36.5	39.6
Worcestershire	⬆	1,755	37.3	35.9	38.7
Telford and Wrekin	⬆	-	*	-	-

Percentage of caesarean sections in Shropshire including nearest statistical neighbours and England, 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↑	-	209,753	40.9	40.7	41.0
Neighbours average	–	-	-	-	-	-
Herefordshire	↑	3	660	45.5	43.0	48.2
Shropshire	↑	-	120	41.4*	36.7	48.0
Cumberland	↑	7	910	41.4	39.4	43.6
Westmorland and Furness	↑	5	630	41.3	38.8	43.7
Cheshire East	↑	15	1,340	41.0	39.3	42.7
Dorset	↑	12	915	40.9	38.9	42.9
Somerset UA	↑	4	1,770	40.5	39.1	42.0
West Berkshire	↑	13	530	40.3	37.8	43.1
Gloucestershire	↑	9	2,275	40.1	38.8	41.4
Wiltshire	↑	2	1,640	39.5	38.0	41.0
East Riding of Yorkshire	↑	6	970	38.6	36.7	40.6
Northumberland	↑	10	875	38.3	36.4	40.4
Suffolk	↑	8	2,090	36.9	35.7	38.2
North Yorkshire UA	↑	1	1,595	35.3	34.0	36.8
Devon	↑	14	2,000	32.9	31.8	34.2
Cornwall	–	11	600	29.3*	27.5	31.4

Percentage of caesarean sections in Shropshire, with West Midlands and England comparisons, 2013-14 to 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID



Recent trend: ↑ Increasing & getting worse

Period		Shropshire Count	Value	95% Lower CI	95% Upper CI	West Midlands	England
2013/14	●	425	16.8%	15.3%	18.2%	25.3%	25.4%
2014/15	●	425	17.4%	16.0%	19.0%	25.9%	25.8%
2015/16	●	475	18.6%	17.1%	20.1%	27.1%	26.3%
2016/17	●	535	20.6%	19.1%	22.2%	27.5%	27.1%
2017/18	●	480	20.2%	18.6%	21.8%	28.5%	27.9%
2018/19	●	500	21.6%	19.9%	23.3%	29.4%	29.2%
2019/20	●	535	23.5%	21.7%	25.2%	30.6%	30.1%
2020/21	●	630	28.0%	26.2%	29.9%	32.8%	32.5%
2021/22	●	640	29.4%	27.4%	31.3%	34.7%	34.7%
2022/23	●	100	36.4%*	31.0%	42.3%	37.6%	37.8%
2023/24	●	120	41.4%*	36.7%	48.0%	40.2%	40.9%

Infant mortality rate

Infant mortality is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions. Deaths occurring during the first 28 days of life (the neonatal period) in particular, are considered to reflect the health and care of both mother and newborn. Reducing infant mortality overall and the gap between the richest and poorest groups are part of the Government's strategy for public health (Healthy Lives, Healthy People: Our Strategy for Public Health November 2010).

This is defined as the number of infant deaths aged under 1 year that were registered in the relevant period expressed as a rate per 1,000 live births. In 2022-24 in Shropshire there were 29 infant deaths under 1 year, which gave a rate of 3.9 per 1,000, which was statistically similar to England (4.2) and statistically lower than the West Midlands (6.1), Shropshire's rate was the third lowest in the region but was the second highest among nearest statistical neighbours. Shropshire's rate has been statistically similar to England's back to 2001-03, even if the last 2 periods have been lower, and whilst the rate now is lower than at the start, it is not statistically different due to the low number of infant deaths.

Infant Mortality Rate in Shropshire, including regional neighbours, West Midlands and England, 2022-24. Source: Child and Maternal Health Profile, Fingertips, OHID

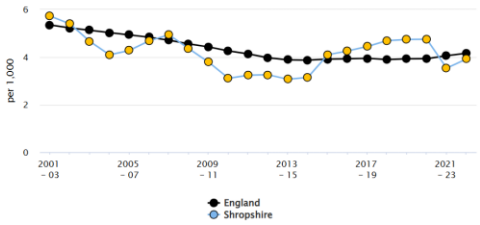
Infant mortality rate 2022 - 24 — Crude rate - per 1,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	7,117	4.2	4.1	4.3
West Midlands region (statistical)	–	1,161	6.1	5.8	6.5
Birmingham	–	384	8.7	7.8	9.6
Sandwell	–	99	7.4	6.0	9.0
Telford and Wrekin	–	42	7.2	5.2	9.7
Wolverhampton	–	70	6.9	5.4	8.7
Coventry	–	75	6.1	4.8	7.7
Walsall	–	60	5.8	4.4	7.5
Stoke-on-Trent	–	52	5.7	4.3	7.5
Worcestershire	–	82	5.2	4.2	6.5
Staffordshire	–	115	4.9	4.1	5.9
Warwickshire	–	77	4.5	3.5	5.6
Dudley	–	43	4.2	3.1	5.7
Shropshire	–	29	3.9	2.6	5.6
Solihull	–	20	3.4	2.1	5.2
Herefordshire	–	13	2.9*	1.5	4.9

Infant Mortality Rates in Shropshire including nearest statistical neighbours and England, 2022-24. Source: Child and Maternal Health Profile, Fingertips, OHID

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	7,117	4.2	4.1	4.3
Neighbours average	–	-	-	-	-	-
West Berkshire	–	13	17	4.0*	2.3	6.3
Shropshire	–	-	29	3.9	2.6	5.6
Suffolk	–	8	76	3.8	3.0	4.7
North Yorkshire UA	–	1	54	3.7	2.8	4.8
Dorset	–	12	28	3.7	2.5	5.4
Cumberland	–	7	25	3.7	2.4	5.4
Gloucestershire	–	9	60	3.4	2.6	4.4
Northumberland	–	10	24	3.3	2.1	4.9
East Riding of Yorkshire	–	6	24	3.1	2.0	4.6
Devon	–	14	56	3.1	2.4	4.0
Herefordshire	–	3	13	2.9*	1.5	4.9
Cornwall	–	11	37	2.9*	2.0	4.0
Cheshire East	–	15	31	2.9	1.9	4.0
Somerset UA	–	4	39	2.8	2.0	3.8
Wiltshire	–	2	30	2.3	1.5	3.3
Westmorland and Furness	–	5	10	2.0*	1.0	3.8

Infant Mortality Rates in Shropshire, with West Midlands and England comparisons, 2001-03 to 2022-24. Source: Child and Maternal Health Profile, Fingertips, OHID



Recent trend: Could not be calculated

Period	Shropshire Count	Value	95% Lower CI	95% Upper CI	Neighbrs average	England
2001 - 03	47	5.7	4.2	7.6	-	5.4
2002 - 04	45	5.4	3.9	7.2	-	5.2
2003 - 05	39	4.7	3.3	6.4	-	5.1
2004 - 06	34	4.1	2.8	5.7	-	5.0
2005 - 07	36	4.3	3.0	5.9	-	4.9
2006 - 08	40	4.7	3.3	6.4	-	4.8
2007 - 09	43	4.9	3.6	6.7	-	4.7
2008 - 10	38	4.4	3.1	6.0	-	4.6
2009 - 11	33	3.8	2.6	5.3	-	4.4
2010 - 12	27	3.1	2.0	4.5	-	4.3
2011 - 13	28	3.2	2.2	4.7	-	4.1
2012 - 14	28	3.3	2.2	4.7	-	4.0
2013 - 15	26	3.1	2.0	4.5	-	3.9
2014 - 16	27	3.1	2.1	4.6	-	3.9
2015 - 17	35	4.1	2.9	5.7	-	3.9
2016 - 18	36	4.3	3.0	5.9	-	3.9
2017 - 19	36	4.4	3.1	6.2	-	3.9
2018 - 20	37	4.7	3.3	6.5	-	3.9
2019 - 21	37	4.7	3.3	6.5	-	3.9
2020 - 22	37	4.8	3.3	6.6	-	3.9
2021 - 23	27	3.5	2.3	5.1	-	4.1
2022 - 24	29	3.9	2.6	5.6	-	4.2

Multiple births

Compared with singletons, babies from multiple births have much higher rates of stillbirth, neonatal mortality, infant mortality, preterm birth, low birth weight, congenital anomalies, and subsequent developmental problems. All of these have consequences for families and for society. Rates of multiple birth are influenced by differences in the proportions of older women giving birth, the extent of use of ovarian stimulation and assisted conception, as well as by other factors. They therefore contribute to variations in rates of mortality and morbidity in infancy and childhood, both geographically and over time.

This is defined as the number of maternities where the outcome is a multiple birth expressed as a rate per 1,000 total maternities. According to the profile in 2022 in Shropshire 34 maternities had an outcome of a multiple birth, which gave a rate of 14.2 per 1,000, which was statistically similar to England (14.5) and the West Midlands (14.5) and is the fifth highest in the region and was the sixth lowest figure among nearest statistical neighbours. Shropshire's rate has nearly always been similar to England's back to 2010, due to the small number of multiple births, and hasn't significantly changed in this time apart from one year.

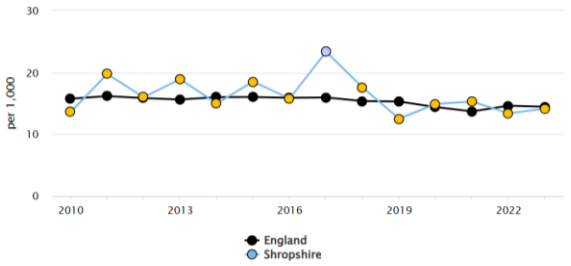
Multiple births rate per 1,000 in Shropshire including regional neighbours, West Midlands and England, 2023. Source: Child and Maternal Health Profile, Fingertips, OHID

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	8,058	14.5	14.1	14.8
West Midlands region (statistical)	↓	825	13.4	12.5	14.3
Telford and Wrekin	→	33	17.4	12.0	24.5
Wolverhampton	→	54	16.0	12.0	20.9
Warwickshire	→	88	15.6	12.5	19.2
Worcestershire	→	74	14.4	11.3	18.1
Shropshire	→	34	14.2	9.8	19.8
Sandwell	→	60	13.9	10.6	17.9
Staffordshire	→	103	13.4	11.0	16.3
Solihull	→	25	13.0	8.4	19.2
Coventry	→	52	13.0	9.7	17.0
Birmingham	→	182	12.9	11.1	14.9
Walsall	→	39	11.7	8.3	16.0
Herefordshire	→	16	10.8	6.1	17.5
Dudley	→	35	10.5	7.3	14.7
Stoke-on-Trent	→	30	10.2	6.9	14.6

Multiple births rate per 1,000 in Shropshire including nearest statistical neighbours and England, 2023. Source: Child and Maternal Health Profile, Fingertips, OHID

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	→	-	8,058	14.5	14.1	14.8
Neighbours average	–	-	-	-	-	-
Wiltshire	→	2	78	18.2	14.4	22.7
North Yorkshire UA	→	1	81	17.2	13.7	21.4
Northumberland	→	10	42	17.2	12.4	23.2
Gloucestershire	→	9	97	16.8	13.7	20.5
Westmorland and Furness	–	5	27	16.7	11.0	24.3
West Berkshire	→	13	21	14.8	9.2	22.6
Cornwall	→	11	63	14.7*	11.3	18.8
Suffolk	→	8	94	14.3	11.6	17.6
Cumberland	–	7	32	14.3	9.8	20.2
Somerset UA	→	4	67	14.3	11.1	18.2
Shropshire	→	-	34	14.2	9.8	19.8
East Riding of Yorkshire	→	6	36	14.1	9.9	19.5
Devon	→	14	80	13.5	10.7	16.8
Cheshire East	→	15	47	13.4	9.8	17.8
Dorset	→	12	28	11.7	7.8	16.9
Herefordshire	→	3	16	10.8	6.1	17.5

Multiple births rate per 1,000 in Shropshire, with West Midlands and England comparisons, 2010 to 2023. Source: Child and Maternal Health Profile, Fingertips, OHID



Recent trend: No significant change

Period		Shropshire Count	Value	95% Lower CI	95% Upper CI	West Midlands	England
2010		39	13.6	9.7	18.6	14.0	15.7
2011		56	19.8	14.9	25.7	15.0	16.2
2012		46	16.0	11.7	21.3	15.5	15.9
2013		53	18.9	14.2	24.7	14.8	15.6
2014		42	15.0	10.8	20.2	14.6	16.0
2015		51	18.5	13.8	24.3	15.7	16.0
2016		46	15.8	11.6	21.1	15.1	15.9
2017		64	23.3	19.0	29.1	14.7	15.9
2018		47	17.6	12.9	23.4	14.8	15.4
2019		32	12.5	8.6	17.7	15.1	15.3
2020		38	14.9	10.6	20.5	14.4	14.4
2021		40	15.3	11.0	20.9	12.8	13.7
2022		34	13.4	9.3	18.7	13.1	14.6
2023		34	14.2	9.8	19.8	13.4	14.5

Admissions of babies under 14 days

High levels of admissions of either mother or babies soon after birth can suggest problems with either the timing or quality of health assessments before the initial transfer or with the postnatal care once the mother is home. Dehydration and jaundice are two common reasons for re-admission of babies and are often linked to problems with feeding.

This indicator is defined as the number of emergency admissions from babies aged 0-13 days (inclusive) expressed as a crude rate per 1,000 deliveries (which comes from NHS England, HES and Admitted Patient Care). In 2022-23 and 2023-24, OHID have identified a HES data quality issue affecting the Shropshire and Telford & Wrekin local authorities data as SATH did not submit complete HES maternity data, so these areas results should be treated with caution. As a result, Shropshire appears to have a particularly high rate compared to other areas. In 2023-24, the rate for England was 88.7 and the West Midlands 99.4, and both of these have been increasing since 2020-21. Prior to the data issues in 2022-23 and 2023-24, the rates for Shropshire in 2020-21 (82.2, 185 children) and 2021-22 (89.7 195 children) were both statistically similar to England (77.6 and 81.6), although rising. Prior to 2018-19, Shropshire had four years where it was significantly below England.

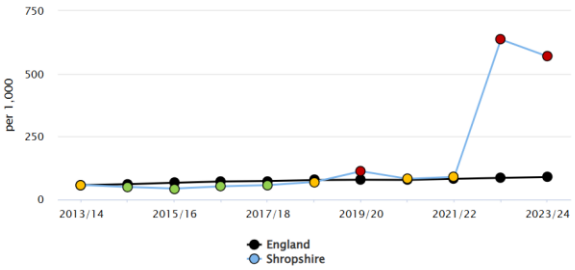
Admissions of babies under 14 days per 1,000 in Shropshire, regional neighbours, West Midlands and England, 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↑	45,538	88.7	87.9	89.5
West Midlands region (statistical)	↑	5,480	99.4	96.7	102.0
Shropshire	→	165	569.0*	487.1	665.0
Stoke-on-Trent	↑	585	201.0	185.1	218.0
Walsall	↑	520	178.4	162.9	193.9
Staffordshire	↑	985	139.2	131.0	148.5
Warwickshire	↑	550	104.8	96.0	113.7
Sandwell	→	425	103.4	93.3	113.2
Herefordshire	↓	120	82.8	69.1	99.6
Wolverhampton	→	250	76.6	66.8	86.0
Solihull	→	140	76.5	63.4	89.1
Coventry	→	260	66.2	57.9	74.2
Birmingham	→	915	64.5	60.5	69.0
Dudley	↑	190	59.9	51.1	68.4
Worcestershire	↓	200	42.6	36.7	48.6
Telford and Wrekin	↑	-	*	-	-

Admissions of babies under 14 days per 1,000 in Shropshire, statistical neighbours and England, 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↑	-	45,538	88.7	87.9	89.5
Neighbours average	–	-	-	-	-	-
Shropshire	→	-	165	569.0*	487.1	665.0
Cornwall	–	11	435	212.7*	194.3	234.9
Suffolk	→	8	750	132.5	122.9	142.0
Cheshire East	→	15	405	123.9	111.8	136.2
Northumberland	↑	10	270	118.2	105.0	133.7
North Yorkshire UA	–	1	530	117.4	107.6	127.8
Somerset UA	–	4	430	98.4	89.1	107.9
Dorset	→	12	200	89.5	77.1	102.3
Westmorland and Furness	→	5	135	88.5	75.3	106.1
Herefordshire	↓	3	120	82.8	69.1	99.6
Wiltshire	→	2	335	80.7	71.8	89.3
East Riding of Yorkshire	→	6	185	73.7	62.8	84.3
Devon	↓	14	435	71.7	64.9	78.6
Gloucestershire	→	9	385	67.8	60.9	74.6
Cumberland	→	7	145	65.9	55.7	77.6
West Berkshire	→	13	85	64.6	51.6	79.9

Admissions of babies under 14 days per 1,000 in Shropshire, including West Midlands and England comparisons, 2013-14 to 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID



Recent trend: → No significant change

Period		Shropshire Count	Value	95% Lower CI	95% Upper CI	Neighbrs average	England
2013/14	●	145	57.2	49.0	68.2	-	56.7
2014/15	●	120	49.2	40.8	58.8	-	60.7
2015/16	●	110	43.1	36.1	52.7	-	66.3
2016/17	●	135	52.0	43.6	61.6	-	71.0
2017/18	●	135	56.7	46.8	66.2	-	72.8
2018/19	●	160	69.1	58.1	79.8	-	77.0
2019/20	●	255	112.1	99.1	127.1	-	78.1
2020/21	●	185	82.2	71.2	95.5	-	77.6
2021/22	●	195	89.7	76.6	102.1	-	81.6
2022/23	●	175	636.4*	545.0	736.5	-	85.7
2023/24	●	165	569.0*	487.1	665.0	-	88.7

● Emergency Admissions for Gastroenteritis (0-4 years)

This indicator can be used to monitor success in treatment outside hospital of types of childhood gastroenteritis that have limited morbidity or need for hospital-based care, and low mortality. This could be through better management of infections and better support for young parents in the management of illnesses in the home. It also can be used to monitor the success of preventative measure such as encouraging breastfeeding, better diet and hygiene. Treatment and prevention interventions could take the form of providing support as well as facilitating access to health advice and therapy through the NHS.

This rate is calculated by the number of emergency admissions for children aged 0-4 years for gastroenteritis as a primary diagnosis, by the estimated resident population aged 0-4 years to form a rate per 10,000 population. In 2023-24, the rate in Shropshire was 88.7, which was significantly higher than England (67.6) but statistically similar to the West Midlands region (80.3) and was the seventh highest regionally, but was significantly higher than three areas in the region, but significantly lower than two areas in the region. Shropshire was the sixth lowest among its statistical neighbours, but statistically similar to all areas. Shropshire's rate has been significantly worse than England for 11 of the last 12 years, with only 2020-21 being similar (the height of the pandemic), however the rate has been decreasing in the last 3 years, and 23-24 was the lowest rate besides 2020-21.

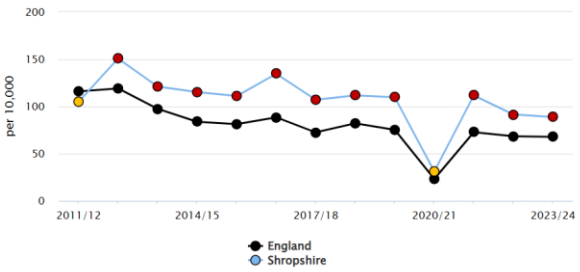
Emergency admissions for gastroenteritis (0 to 4 years) rate per 10,000 in Shropshire, regional neighbours, West Midlands and England, 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	20,725	67.6	66.7	68.6
West Midlands region (statistical)	→	2,710	80.3	77.2	83.3
Telford and Wrekin	↑	175	164.0	141.5	191.2
Walsall	↑	225	123.7	107.5	140.4
Herefordshire	→	100	121.5	96.6	145.1
Wolverhampton	→	165	95.0	82.1	111.9
Birmingham	↑	670	89.8	83.0	96.8
Solihull	↑	100	88.8	72.2	108.0
Shropshire	→	125	88.7	73.8	105.7
Stoke-on-Trent	→	140	87.3	74.0	103.7
Sandwell	→	170	75.3	65.2	88.4
Staffordshire	→	305	69.9	62.3	78.2
Warwickshire	→	215	66.9	57.7	75.9
Worcestershire	→	150	51.4	44.1	61.1
Dudley	→	75	41.6	32.3	51.6
Coventry	→	90	41.5	34.2	52.1

Emergency admissions for gastroenteritis (0 to 4 years) rate per 10,000, including statistical neighbours, and England, 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	→	-	20,725	67.6	66.7	68.6
Neighbours average	–	-	-	-	-	-
Cumberland	↑	7	155	122.5	105.4	145.1
Herefordshire	→	3	100	121.5	96.6	145.1
Cheshire East	→	15	240	117.1	103.2	133.5
Devon	↑	14	405	117.1	106.0	129.1
North Yorkshire UA	↑	1	305	110.9	98.5	123.7
Westmorland and Furness	→	5	100	108.9	89.6	133.7
Dorset	↑	12	150	102.0	87.6	121.1
Northumberland	→	10	140	101.6	85.5	119.9
Gloucestershire	↑	9	300	93.9	84.1	105.8
East Riding of Yorkshire	→	6	135	92.1	76.0	107.5
Shropshire	→	-	125	88.7	73.8	105.7
Somerset UA	↑	4	230	85.8	75.8	98.4
Wiltshire	↑	2	185	74.7	63.6	85.5
Cornwall	→	11	180	71.6*	61.9	83.3
Suffolk	→	8	250	66.8	59.0	75.8
West Berkshire	→	13	45	55.7	41.7	75.9

Emergency admissions for gastroenteritis (0 to 4 years) rate per 10,000 in Shropshire, including West Midlands and England, 2011-12 to 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID



Recent trend: → No significant change

Period		Shropshire Count	Value	95% Lower CI	95% Upper CI	Neighbrs average	England
2011/12	●	165	104.9	90.1	122.8	-	115.8
2012/13	●	235	150.7	130.9	169.9	-	119.0
2013/14	●	185	121.0	105.4	141.1	-	97.4
2014/15	●	175	115.1	97.5	132.1	-	83.7
2015/16	●	165	110.9	93.4	127.8	-	81.2
2016/17	●	200	134.5	115.9	153.8	-	88.4
2017/18	●	160	107.1	92.3	126.4	-	72.5
2018/19	●	165	111.7	96.6	131.6	-	82.0
2019/20	●	160	109.6	92.0	126.5	-	75.2
2020/21	●	45	31.0	22.6	41.5	-	23.0
2021/22	●	160	111.6	95.6	131.0	-	72.6
2022/23	●	130	91.5	77.7	110.1	-	68.4
2023/24	●	125	88.7	73.8	105.7	-	67.6

Local Data

In order to investigate this data indicator, an extract from the Hospital Episode Statistics (HES) was taken which tried to replicate the definitions of this indicator of Shropshire residents, which was successful apart from a couple of minor differences in numbers. The HES extract showed that the number of admissions in 2023-24 were very similar to the year before and the year after, however already up to November 2025, it looks like the number of admissions for 2025-26 are going to be much higher. Over the 3-year period 2022-23 to 2024-25, the gender split was 51% female, 48% male, and the 30% of these admissions were for children aged under 1 and 27% for those aged 1 year old. Deprivation doesn't seem to be so much of a factor in those being admitted, with 31% from those in the middle quintile, and 25% and 21% from those from the 2nd least deprived quintile and 2nd most deprived quintile. 90% of the admissions were children whose ethnicity was 'White', but it is not possible to define the percentages for other groups as the numbers were too small. Of the primary diagnosis, 53% of admissions were 'Viral intestinal infection, unspecified' and 43% were 'Gastroenteritis and colitis of unspecified origin'.

Number of emergency admissions for gastroenteritis (0 to 4 years) in Shropshire, 2018-19 to November 2025. Source: Hospital Episode Statistics

2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26* up to Nov 25
159	153	45	158	127	126	122	110

Number of emergency admissions for gastroenteritis (0 to 4 years) in Shropshire by age, 2022-23 to 2024-25. Source: Hospital Episode Statistics

Years Old	Less than 1	1 year old	2 years old	3 years old	4 years old
Numbers	111	103	68	39	54
Percentage	30%	27%	18%	10%	14%

Number of emergency admissions for gastroenteritis (0 to 4 years) in Shropshire by age group, 2022-23 to 2024-25. Source: Hospital Episode Statistics

IMD2025 Quintile	1 most deprived	2	3	4	5 least deprived
Numbers	26	84	102	69	50
Percentage of those recorded	8%	25%	31%	21%	15%

● Emergency Admissions for Lower Respiratory Tract Infections (0-4 years)

This indicator can be used to monitor success in treatment outside hospital of types of childhood respiratory tract infections that have limited morbidity or need for hospital-based care, and low mortality. This could be through better management of infections and better support for young parents in the management of illnesses in the home.
It also can be used to monitor the success of preventative measure such as encouraging breastfeeding, better diet and hygiene. Treatment and prevention interventions could take the form of providing support as well as facilitating access to health advice and therapy through the NHS.

This rate is calculated by the number of emergency admissions for children aged 0-4 years for a respiratory tract infection as a primary diagnosis, by the estimated resident population aged 0-4 years to form a rate per 10,000 population. In 2023-24, the rate in Shropshire was 209.4, which was statistically similar to England (207.7) and the West Midlands region

(201.6) and was the sixth highest regionally, but was significantly higher than two areas in the region, but significantly lower than two areas in the region. Shropshire was the lowest among its statistical neighbours, and significantly lower than the neighbourhood average and eight of its statistical neighbours. Shropshire's rate has been statistically similar to England for four out of the last five years, with only 2020-21 being significantly lower (the height of the pandemic), however whilst the most recent rate was slightly lower than the year before, these last 2 years are higher than pre-pandemic – significantly higher than 2017-18, and before 2015-16.

Emergency Admissions for Lower Respiratory Tract Infections (0-4 years) rate per 10,000 in Shropshire, including regional neighbours, with West Midlands and England comparisons, 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID

Emergency admissions for lower respiratory tract infections (0 to 4 years) 2023/24 — Crude rate - per 10,000

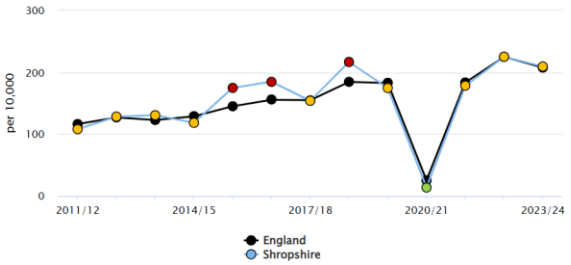
Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↑	63,661	207.7	206.1	209.3
West Midlands region (statistical)	↑	6,805	201.6	196.8	206.4
Walsall	↑	615	338.1	310.8	364.7
Telford and Wrekin	↑	285	267.1	237.8	300.9
Herefordshire	↑	215	261.2	229.7	301.1
Stoke-on-Trent	↑	400	249.5	225.0	274.5
Staffordshire	↑	930	213.2	199.3	226.9
Shropshire	↑	295	209.4	186.2	234.7
Wolverhampton	↑	355	204.5	183.7	226.9
Solihull	↑	215	190.9	166.2	218.1
Sandwell	↑	420	186.0	168.6	204.6
Warwickshire	↑	585	182.1	167.1	196.9
Birmingham	↑	1,345	180.3	170.7	190.1
Worcestershire	↑	495	169.6	155.7	186.0
Coventry	↑	365	168.5	152.1	187.1
Dudley	↑	285	158.2	140.9	178.3

Emergency Admissions for Lower Respiratory Tract Infections (0-4 years) rate per 10,000 in Shropshire, including statistical neighbours, with England comparison, 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID

Emergency admissions for lower respiratory tract infections (0 to 4 years) 2023/24 — Crude rate - per 10,000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↑	-	63,661	207.7	206.1	209.3
Neighbours average	–	-	8,500	262.3*	256.8	267.9
Devon	↑	14	1,200	347.1	328.3	367.9
North Yorkshire UA	↑	1	890	323.6	302.0	344.8
Westmorland and Furness	↑	5	275	299.5	264.1	336.0
Northumberland	↑	10	400	290.4	262.6	320.3
Cumberland	↑	7	365	288.4	258.8	318.8
Cheshire East	↑	15	580	283.1	260.5	307.1
Dorset	↑	12	390	265.2	238.8	292.1
Herefordshire	↑	3	215	261.2	229.7	301.1
Somerset UA	↑	4	695	259.3	240.7	279.6
West Berkshire	↑	13	190	235.0	203.9	272.3
Gloucestershire	↑	9	740	231.5	215.8	249.5
East Riding of Yorkshire	↑	6	335	228.6	205.4	255.1
Wiltshire	↑	2	560	226.3	207.9	245.8
Suffolk	↑	8	840	224.3	209.4	240.0
Cornwall	→	11	530	210.9*	192.9	229.2
Shropshire	↑	-	295	209.4	186.2	234.7

Emergency Admissions for Lower Respiratory Tract Infections (0-4 years) rate per 10,000, including West Midlands and England comparisons, 2011-12 to 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID



Recent trend: ↑ Increasing & getting worse

Period		Shropshire Count	Value	95% Lower CI	95% Upper CI	West Midlands	England
2011/12		170	108.1	93.0	126.3	129.2	116.3
2012/13		200	128.3	110.5	146.6	149.7	127.1
2013/14		200	130.8	112.7	149.5	140.4	122.8
2014/15		180	118.4	102.9	138.4	138.7	128.8
2015/16		260	174.8	154.2	197.4	169.6	145.1
2016/17		275	184.9	163.1	207.4	164.5	155.5
2017/18		230	153.9	135.3	175.8	156.4	154.9
2018/19		320	216.6	194.8	243.2	184.1	184.5
2019/20		255	174.7	154.5	198.2	162.9	182.8
2020/21		20	13.8	7.9	20.5	23.9	25.2
2021/22		255	177.8	156.7	201.1	171.7	183.4
2022/23		320	225.1	200.5	250.5	220.0	225.1
2023/24		295	209.4	186.2	234.7	201.6	207.7

Local Data

In order to investigate this data indicator, an extract from the Hospital Episode Statistics (HES) was taken which tried to replicate the definitions of this indicator of Shropshire residents, which was successful apart from a couple of minor differences in numbers. The HES extract showed that the number of admissions in 2023-24 were very similar to the year before and the year after, and how 2025-26 would likely be in the data up to November 2025. Over the 3-year period 2022-23 to 2024-25, the gender split was 41% female, 59% male, and the 81% of these admissions were for children aged under 1 and 11% for those aged 1 year old. Deprivation doesn't seem to be so much of a factor in those being admitted, with 37% from those in the middle quintile, and 20% and 19% from those from the 2nd least deprived quintile and 2nd most deprived quintile, with 17% from those in the least deprived quintile. 89% of the admissions were children whose ethnicity was 'White', but it is not possible to define the percentages for other groups as the numbers were too small. Of the primary diagnosis, 71% of admissions were 'Acute bronchiolitis, unspecified' and 13% were 'Acute bronchiolitis due to respiratory syncytial virus' and 7% were 'Lobar pneumonia, unspecified'.

Number of emergency admissions for lower respiratory tract infections (0 to 4 years) in Shropshire, 2018-19 to November 2025. Source: Hospital Episode Statistics

2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25	2025-26* up to Nov 25
317	246	20	237	296	288	282	128

Number of emergency admissions for lower respiratory tract infections (0 to 4 years) in Shropshire by age, 2022-23 to 2024-25. Source: Hospital Episode Statistics

Years Old	Less than 1	1 year old	2 years old	3 years old
Numbers	702	92	35	27
Percentage	81%	11%	4%	3%

Number of emergency admissions for lower respiratory tract infections (0 to 4 years) in Shropshire by age group, 2022-23 to 2024-25. Source: Hospital Episode Statistics

IMD2025 Quintile	1 most deprived	2	3	4	5 least deprived
Numbers	26	84	102	69	50
Percentage of those recorded	8%	25%	31%	21%	15%

Additional data

Live births

According to the NOMIS website which contains official census and labour market statistics, there were 2,427 live births in Shropshire in 2023 and 2,406 in 2024 – which was the lowest there has been in the last 12 years and in 2016 there were as many as 2,947 births[25].

Year	Under 20	Under 18	20-24	25-29	30-34	35-39	40-44	45+	Total
2013	124	27	502	817	849	443	100	8	2,843
2014	108	25	468	884	807	451	106	10	2,834
2015	93	18	503	808	845	417	122	7	2,795
2016	84	15	499	872	906	472	109	5	2,947
2017	98	24	427	777	905	482	92	12	2,793
2018	81	14	427	811	833	473	82	6	2,713
2019	68	12	401	741	852	435	84	6	2,587
2020	69	16	360	737	897	422	86	6	2,578
2021	60	6	326	728	946	487	90	2	2,639
2022	75	11	328	691	902	484	82	5	2,567
2023	47	9	286	667	871	440	108	8	2,427
2024	64	19	250	637	882	476	89	8	2,406
Percentage of births in the year by Mothers Age Group									
Year	**Under 20**	**Under 18**	**20-24**	**25-29**	**30-34**	**35-39**	**40-44**	**45 +**	**Total**
2013	4%	1%	18%	29%	30%	16%	4%	0%	2,843
2014	4%	1%	17%	31%	28%	16%	4%	0%	2,834
2015	3%	1%	18%	29%	30%	15%	4%	0%	2,795
2016	3%	1%	17%	30%	31%	16%	4%	0%	2,947
2017	4%	1%	15%	28%	32%	17%	3%	0%	2,793
2018	3%	1%	16%	30%	31%	17%	3%	0%	2,713
2019	3%	0%	16%	29%	33%	17%	3%	0%	2,587
2020	3%	1%	14%	29%	35%	16%	3%	0%	2,578
2021	2%	0%	12%	28%	36%	18%	3%	0%	2,639
2022	3%	0%	13%	27%	35%	19%	3%	0%	2,567
2023	2%	0%	12%	27%	36%	18%	4%	0%	2,427
2024	3%	1%	10%	26%	37%	20%	4%	0%	2,406

The number of live births was highest in Bayston Hill, Column and Sutton Ward (222), Oswestry East (162), Market Drayton West (153) and Shifnal South and Cosford (143)[26].

Live births in Shropshire by electoral ward, 2023 and 2024. Source: Live births in England and Wales for small geographical areas, NOMIS [26]

Electoral wards	Live births	Percentage of live births
Bayston Hill, Column and Sutton	222	4.6%
Oswestry East	162	3.4%
Market Drayton West	153	3.2%
Shifnal South and Cosford	143	3.0%
Whitchurch North	141	2.9%
Gobowen, Selattyn and Weston Rhyn	126	2.6%
Shifnal North	117	2.4%

[25] NOMIS Live births
[26] Live births in England and Wales for small geographical areas

Market Drayton East	104	2.2%
Battlefield	103	2.1%
Harlescott	103	2.1%
Abbey (Shropshire)	98	2.0%
Radbrook	98	2.0%
Wem	98	2.0%
Shawbury	93	1.9%
Bridgnorth West and Tasley	91	1.9%
Cleobury Mortimer	89	1.8%
Sundorne	89	1.8%
Church Stretton and Craven Arms	84	1.7%
Bagley	82	1.7%
Castlefields and Ditherington	80	1.7%
Bridgnorth East and Astley Abbotts	77	1.6%
Albrighton	76	1.6%
Underdale	75	1.6%
Quarry and Coton Hill	74	1.5%
Loton	72	1.5%
St Oswald (Shropshire)	72	1.5%
Whittington (Shropshire)	72	1.5%
Rea Valley	71	1.5%
Porthill	70	1.4%
Severn Valley	70	1.4%
Longden	69	1.4%
Ruyton and Baschurch	69	1.4%
Bowbrook (Shropshire)	68	1.4%
Copthorne	68	1.4%
Burnell	67	1.4%
Meole	67	1.4%
Llanymynech	66	1.4%
St Martin's (Shropshire)	65	1.3%
Prees	64	1.3%
Cheswardine	63	1.3%
Clee	63	1.3%
Highley	63	1.3%
Tern	61	1.3%
Monkmoor	60	1.2%
Broseley	59	1.2%
Ellesmere Urban	59	1.2%
Ludlow East	59	1.2%
Whitchurch South	58	1.2%
Ludlow South	57	1.2%
Oswestry West	57	1.2%
The Meres	55	1.1%
Belle Vue (Shropshire)	51	1.1%
Oswestry South	48	1.0%
Alveley and Claverley	47	1.0%
Worfield	45	0.9%
Hodnet	44	0.9%
Clun	43	0.9%
Much Wenlock	43	0.9%
Corvedale	42	0.9%
Brown Clee	41	0.8%
Bishop's Castle	40	0.8%
Ludlow North	36	0.7%
Chirbury and Worthen	31	0.6%
Total	4,833	100.0%

Age of mothers

In 2024, there were more live births (882, 36.7%) to mothers aged 30-34 years than any other age group in Shropshire and this percentage in this age group was greater than the West Midland (33.1%) and England average (34.8%) [27]. In 2024 in Shropshire, 60.5% of mothers were aged over 30, higher than the regional figure of 55.4% but lower than the national average of 61.1%.

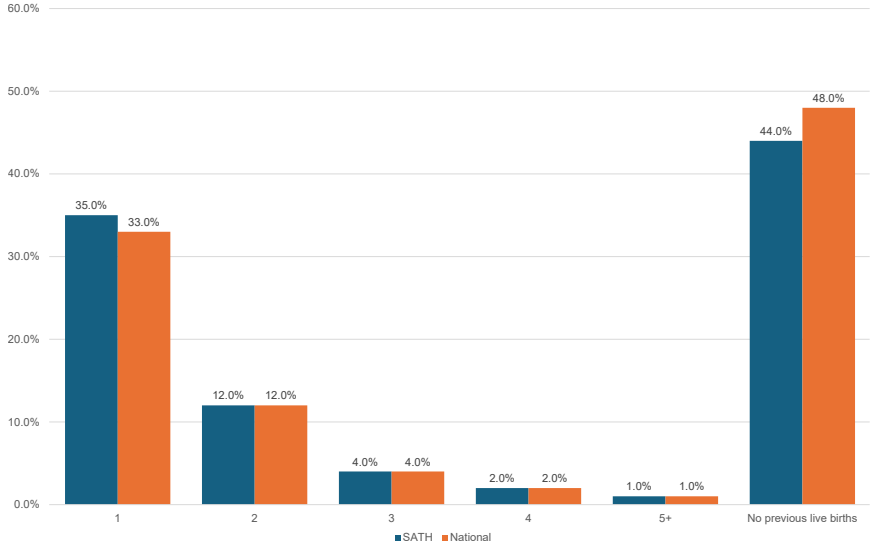
Live births in Shropshire, West Midlands and England by age of mother, 2024. Source: Live births in England and Wales down to local authority local area, NOMIS [27]

Age of mother	Shropshire live births	Shropshire	West Midlands	England
Mother aged under 20	64	2.7%	2.7%	2.2%
Mother aged under 18	19	0.8%	0.6%	0.5%
Mother aged 20-24	250	10.4%	13.4%	11.2%
Mother aged 25-29	637	26.5%	28.6%	25.5%
Mother aged 30-34	882	36.7%	33.1%	34.8%
Mother aged 35-39	476	19.8%	18.0%	21.0%
Mother aged 40-44	89	3.7%	4.0%	4.8%
Mother aged 45 and over	8	0.3%	0.3%	0.5%
Age of mother unknown or not stated	0	0.0%	0.0%	0.0%
Mother aged 30 or over	1,455	60.5%	55.4%	61.1%
Total	2,406			

Mother's previous births

In March 2025, 44% of mothers at SATH had no previous live births, slightly below the national figure of 48%, meanwhile 35% of mothers had one previous live birth and 12% had 2 previous live births[28].

Mother's previous births, Shrewsbury and Telford Hospital compared to the national average, March 2025. Source: National Maternity Dashboard, NHS England.



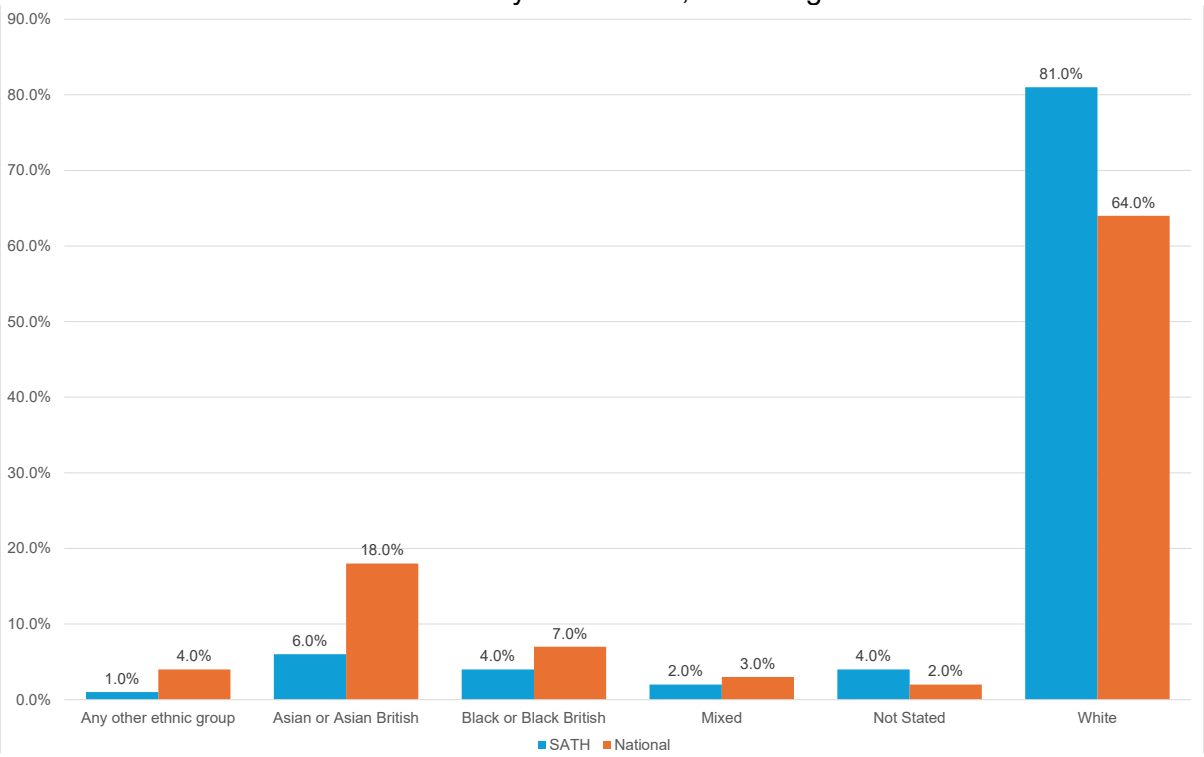
[27] NOMIS - Live births in England and Wales down to local authority area
[28] National Maternity dashboard

Local analysis shows that just 3 in 10 (29%, 706) mothers who recorded a booking appointment during the 2023/24 period were identified as not having previously recorded a live birth, with most new mothers (81%, 570) found to be of a typical age (20 to 34) at the time of their booking. Further analysis found that 84% (592) of new mothers were from a White British ethnicity and 34% came from the middle deprivation quintile (IMD2019) with just 6% (44) coming from a deprived Core20 neighbourhood and 15% (107) coming from the least deprived neighbourhoods.

Ethnicity of mothers

In March 2025, 81% of mothers in Shropshire were classified as 'White', which was above the national figure of 64%. During the same period, 13% of mothers reported themselves as belonging to Black or ethnic minority communities, below the national average of 32% [29].

Ethnicity of mother, Shrewsbury and Telford Hospital compared to the national average, March 2025. Source: National Maternity Dashboard, NHS England.



Complex social factors

As part of the maternity reporting system midwives identify whether complex social factors are present by identifying whether or not the mother meets one or more of the following characteristics:

- Under the age of 20,
- experiencing domestic abuse,

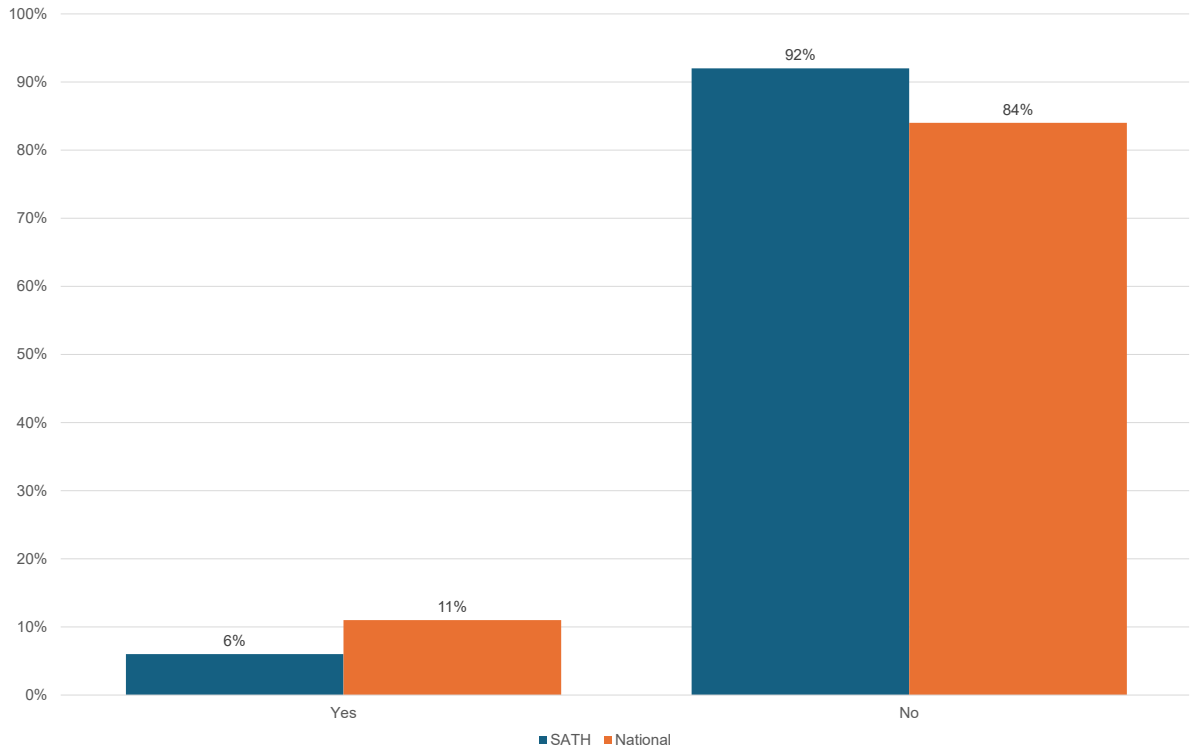
[29] National Maternity dashboard

- a recent migrant, asylum seeker or refugee,
- has difficulty reading or speaking English, and
- misuse substances including alcohol and drugs.

Women in these groups may have additional needs which should be considered when planning services. For example, women aged under 20 can be reluctant to use antenatal services because they feel uncomfortable when most of the other women attending are older or encounter practical difficulties with getting to such services. If a mother misuses alcohol, illicit drugs, solvents or medicines this can place her baby at greater risk of poorer outcomes. For a more in-depth understanding of this topic please see the NICE Clinical Guideline CG110: Pregnancy and Complex Social factors: a model for service provision for pregnant women with complex social factors.

According to the national maternity dashboard, 6% of women attending booking appointments at SATH had complex social factors, which is lower than the 11% nationally.

Complex Social Factors, Shrewsbury and Telford Hospital compared to the national average, March 2025. Source: National Maternity Dashboard, NHS England.



The LMNS dashboard reports that for the 2023-24 period 6% (140) mothers from Shropshire were identified as having complex social factors at their first antenatal appointment. With local analysis using the MSDS dataset suggests that on average around 12 such women were identified each month over the course of the 2023/24 period.

Looking at the data by ethnicity showed that bookings from mothers with an *other* ethnicity recorded the highest proportion of complex social factors (21%), however the numbers involved are quite small (5/23). The second highest proportion was found among mothers

from a *White other* ethnicity (20%) but again the numbers are small (24/118). Further analysis using a larger sample size is recommended in order to get a clearer understanding of the link between ethnicity and complex social factors within Shropshire,

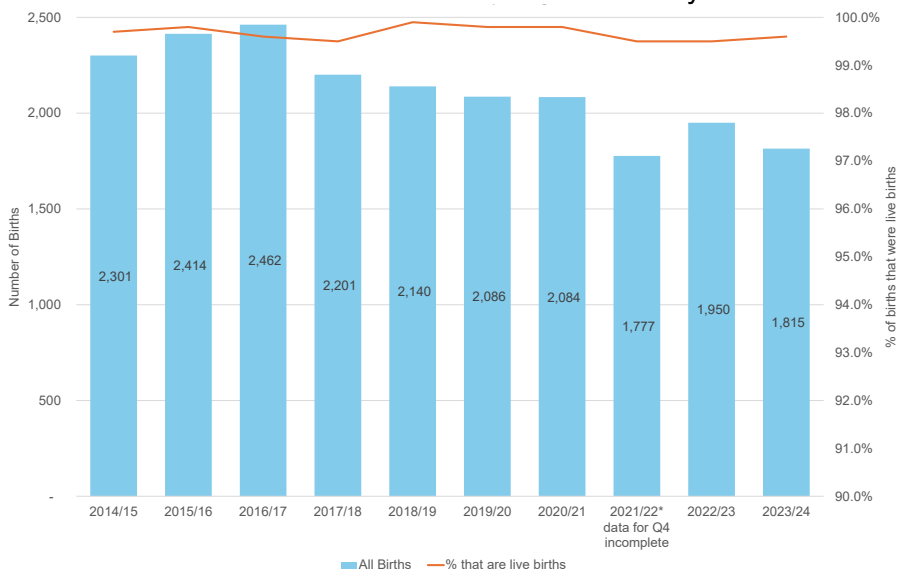
As with smoking, deprivation was found to be a clear driver of complex social factors with 15% of mothers living within the most deprived neighbourhoods (IMD2019) identified as having a complex social factor at their first antenatal booking, compared to just 3% of mothers from the least deprived neighbourhood. Again, as with the ethnicity data the numbers involved here are small, with just 25 of 165 bookings from the most deprived communities as identified as having complex social factors.

Additional SATH Maternity Data Analysis

Data obtained from the maternity unit at SATH has been used for this section, to clarify, this data is from a quarterly extract of deliveries that occurred at SATH, where the mother is registered within Shropshire, this does not include Telford and Wrekin. Although this data is about deliveries, the dataset contains information about this cohort's booking appointment. However, the maternity data system changed in the last quarter of 2021-22 and some information previously received was no longer.

The number of births over the last 10 years has been on a year-on-year downward trend, from a high of 2,462 in 2016-17, to 1,815 in 2023-24 – data in 2021-22 was incomplete due to a change in the maternity system in the final quarter. Throughout this period at least 99.5% of deliveries were recorded as live births.

Number of Shropshire births within SATH between 2014-15 and 2023-24 and the percentage of these that were live births. Source: SATH maternity database

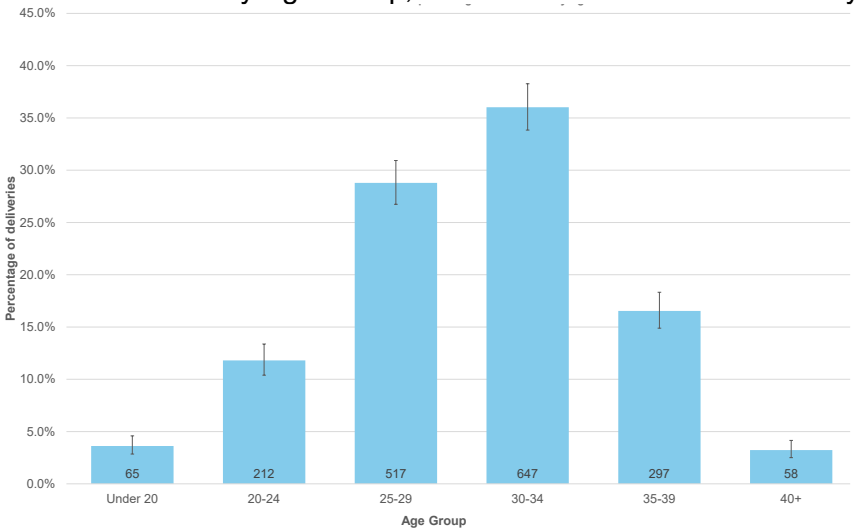


*data for Quarter 4 2021/22 was incomplete due to a change in the maternity database

Age of Mother

In 2024-25, over a third of births that occurred at SATH were mothers aged 30-34 (36%, 647 deliveries), with 28.8% from those aged 25-29 and 16.5% from those aged 35-39 and there were 58 births for mothers aged over 40, 65 from mothers aged under 20.

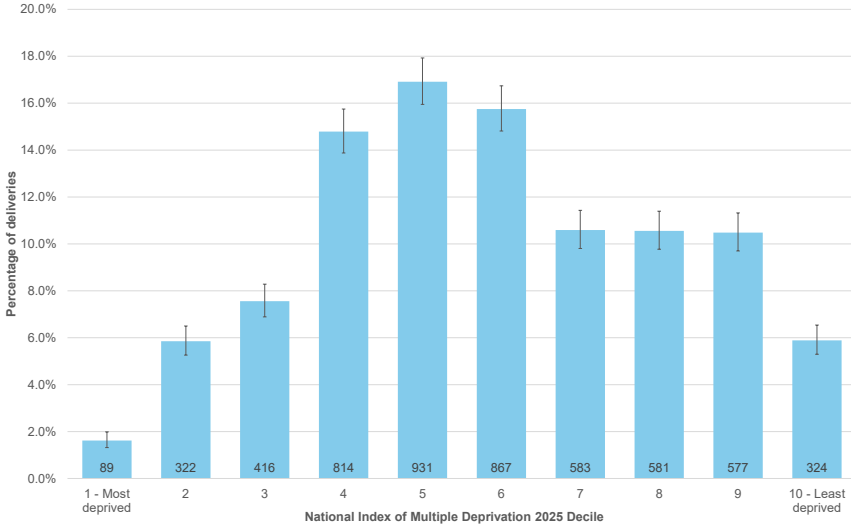
Shropshire births within SATH by Age Group, 2024/25. Source: SATH maternity database



Deprivation

There are several health outcomes that have been found to be worse in mothers and babies from more deprived communities. Analysis of the index of multiple deprivation 2025 (IMD) from SATH births in the 3-year period 2022-23 to 2024-25 showed that 58% of deliveries (3,195) came from the middle four national deciles (4,5,6 and 7), whilst 1.6% (89) came from the most deprived national decile, and 5.9% (322) from the second most deprived decile.

Shropshire births within SATH by National IMD 2025 Decile, 2022-23 to 2024-25. Source: SATH maternity database



Area of Shropshire

The home postcode of the mother allowed for an analysis of where the mother lives within Shropshire who delivered at SATH, but rather than breaking this down by electoral ward, this analysis has been done via the place plan areas, which is a geographical area used in planning, and there is also a locality based JSNA being developed for each one. There are 18 place plan areas in Shropshire, but these vary in size and population and due to the small number of the population in some areas, the maternity data was analysed for 3 years (2022-23 to 2024-25), which meant a total of 5,504 deliveries – 44.4% were for mothers who lived in the Shrewsbury place plan area. Despite looking at 3 years of data, several of the place plan areas had under 2% of deliveries – this might reflect smaller numbers of women of child bearing age in those areas and also that some of the pregnant women in those areas delivered at another hospital provider which is nearer to them.

Shropshire births within SATH by Place Plan Area, 2022-23 to 2024-25. Source: SATH maternity database

Place Plan Area	Number of deliveries	Percentage of deliveries
Albrighton	107	1.9%
Bishop's Castle	140	2.5%
Bridgnorth	311	5.7%
Broseley	100	1.8%
Church Stretton	84	1.5%
Cleobury Mortimer	20	0.4%
Craven Arms	119	2.2%
Ellesmere	77	1.4%
Highley	79	1.4%
Ludlow	118	2.1%
Market Drayton	375	6.8%
Much Wenlock	113	2.1%
Oswestry	73	1.3%
Pontesbury and Minsterley	486	8.8%
Shifnal	286	5.2%
Shrewsbury	2445	44.4%
Wem	297	5.4%
Whitchurch	274	5.0%
Total	**5,504**	**100.0%**

Breastfeeding

The importance of first feed breastmilk is twofold; the establishment and continuation of breastfeeding begins with initiation and first feed, and the feeding of colostrum in the first hours and days of life confers sophisticated protective benefits. Increases in breastfeeding are expected to reduce illness in young children, have health benefits for the infant and the mother and result in cost savings to the NHS through reduced hospital admission for the treatment of infection in infants. Breast milk provides the ideal nutrition for infants in the first stages of life. There is evidence that not breastfeeding is linked to an increased risk of gastrointestinal and respiratory tract infections. There is growing evidence that not breastfeeding might increase the risk of obesity later in life. Breastfeeding is associated with improved maternal health: lower risk of breast cancer and endometriosis, and greater postpartum weight loss and lower body mass index (BMI) in the longer term. There is some

evidence to suggest that breastfeeding protects against ovarian cancer. Mothers who do not breastfeed may find it more difficult to return to their pre-pregnancy weight

The child health OHID profile includes a measure which looks at the percentage of live births whose first feed was breastmilk, out of those births where the feed status was known, but it reports that the data for earlier years may be subject to more data quality issues and should be used with caution, but that the data quality is expected to improve over time, but for this reason this indicator is classed as being "in development".

In 2023-24 Shropshire had the highest percentage in the West Midlands with 81.7%, which was statistically higher than the West Midlands and England and Shropshire was the second highest among its nearest statistical neighbours. The trends data shows that since its introduction, Shropshire has been significantly above West Midlands and England, and that rates have increased – although in 2022-23 they were as high 96.7%.

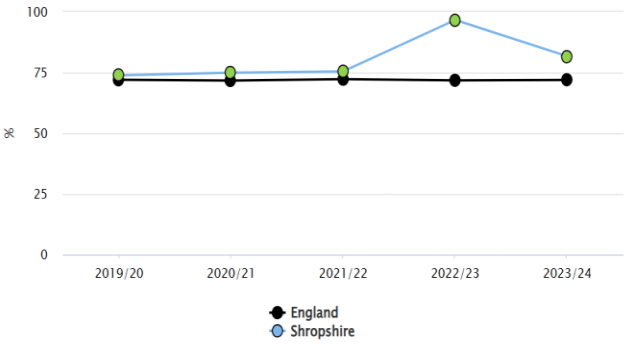
Percentage of baby's whose first feed was breastmilk, including regional neighbours, West Midlands and England, 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	345,565	71.9	71.8	72.1
West Midlands region (statistical)	↑	38,580	69.7	69.3	70.1
Shropshire	↑	1,720	81.7	79.9	83.2
Telford and Wrekin	↑	1,445	79.8	77.9	81.6
Herefordshire	→	1,020	77.9	75.7	80.1
Coventry	→	2,680	75.8	74.4	77.2
Warwickshire	↓	3,700	73.2	72.0	74.4
Birmingham	→	9,310	72.0	71.2	72.8
Worcestershire	↑	3,190	71.7	70.3	72.9
Solihull	→	1,195	69.5	67.1	71.5
Sandwell	→	2,825	69.2	67.9	70.7
Wolverhampton	→	2,055	67.8	66.1	69.4
Stoke-on-Trent	→	1,655	64.9	63.0	66.7
Dudley	→	1,880	63.6	61.8	65.3
Staffordshire	→	4,090	62.1	61.0	63.3
Walsall	→	1,815	56.0	54.4	57.8

Percentage of baby's whose first feed was breastmilk, including statistical neighbours, with West Midlands and England, 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	→	-	345,565	71.9	71.8	72.1
Neighbours average	–	-	-	-	-	-
Somerset UA	→	4	3,535	82.0	80.8	83.1
Shropshire	↑	-	1,720	81.7	79.9	83.2
Devon	–	14	3,790	79.5	78.3	80.6
Wiltshire	–	2	3,170	78.1	76.7	79.3
Herefordshire	→	3	1,020	77.9	75.7	80.1
Cornwall	→	11	3,040	76.6*	75.3	77.9
Gloucestershire	↓	9	3,975	76.1	74.9	77.2
Suffolk	→	8	4,345	75.8	74.7	76.9
Dorset	→	12	1,720	75.8	74.0	77.5
West Berkshire	→	13	955	75.5	73.0	77.8
North Yorkshire UA	→	1	3,275	74.8	73.5	76.1
East Riding of Yorkshire	→	6	1,405	70.6	68.5	72.5
Cheshire East	↓	15	2,070	69.2	67.4	70.7
Westmorland and Furness	↑	5	1,000	68.5	66.2	71.0
Northumberland	↓	10	1,165	60.2	58.1	62.5
Cumberland	→	7	1,125	55.8	53.6	57.9

Percentage of baby's whose first feed was breastmilk, including regional neighbours, West Midlands and England, 2019-20 to 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID



Recent trend: ⬆ Increasing & getting better

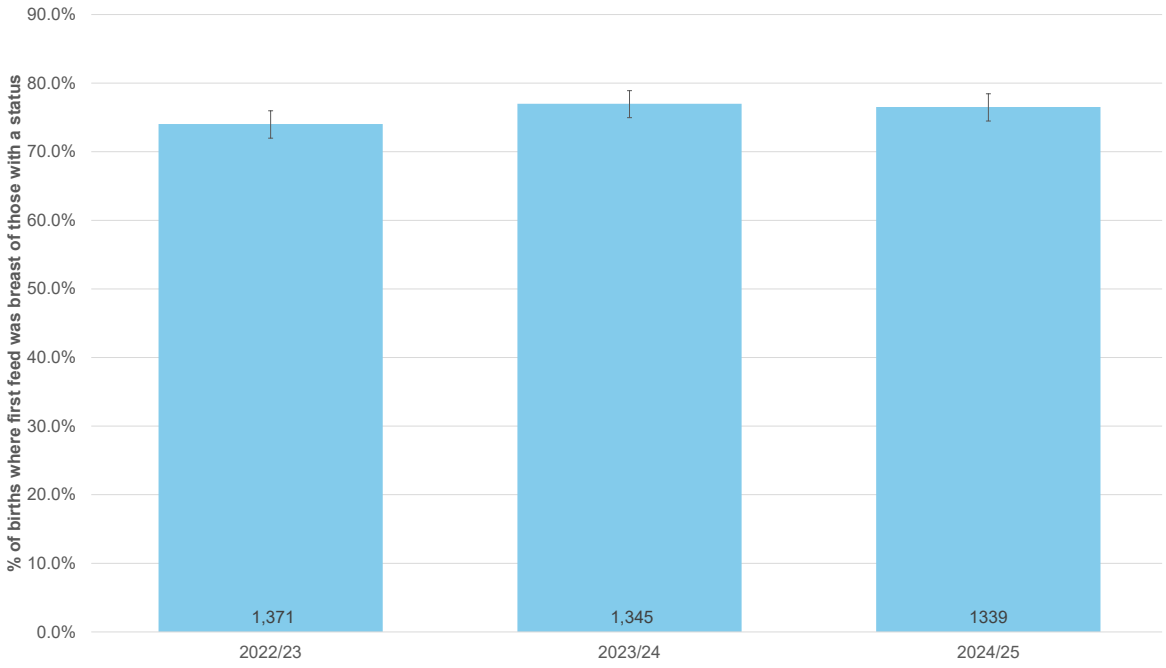
Period		Shropshire Count	Value	95% Lower CI	95% Upper CI	West Midlands	England
2019/20		1,680	73.8%	72.1%	75.7%	67.0%	72.0%
2020/21		1,690	74.9%	73.1%	76.7%	68.3%	71.7%
2021/22		1,675	75.5%	73.5%	77.0%	68.7%	72.2%
2022/23		2,020	96.7%	95.8%	97.4%	69.9%	71.8%
2023/24		1,720	81.7%	79.9%	83.2%	69.7%	71.9%

Source: OHID, based on NHS England data

Indicator Definitions and Supporting Information

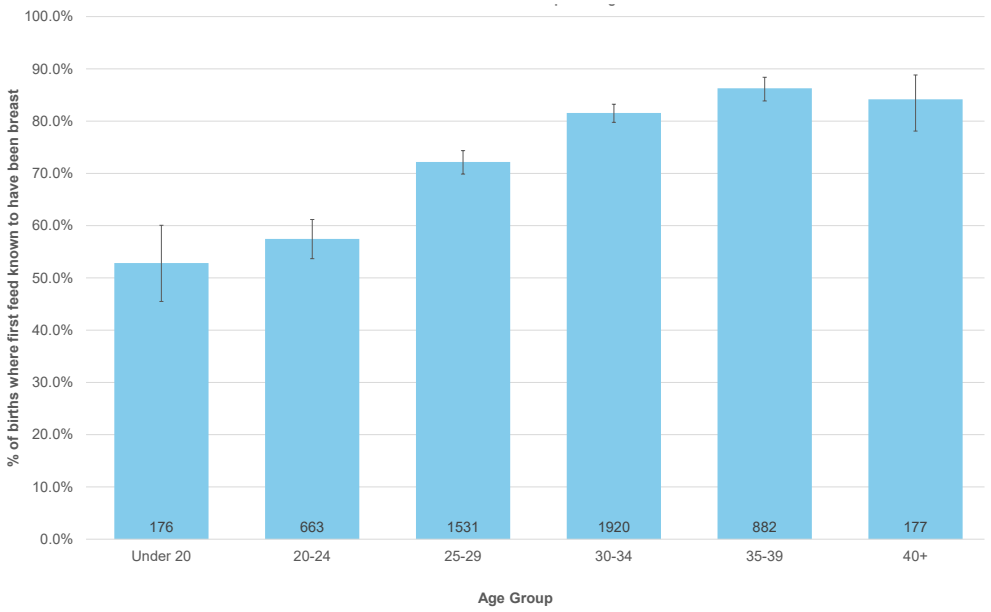
In the local data available from the SATH database, analysis was conducted looking at those deliveries where the first feed was any form of breast or expressed milk as a percentage of those who could be fed or with a known status, and this shows that in the last 3 years the figure for the first feed being breast has slightly increased from 74% to 76.5%.

Percentage of deliveries where babies first feed was breast, 2022-23 to 2024-25. Source: SATH Maternity Database



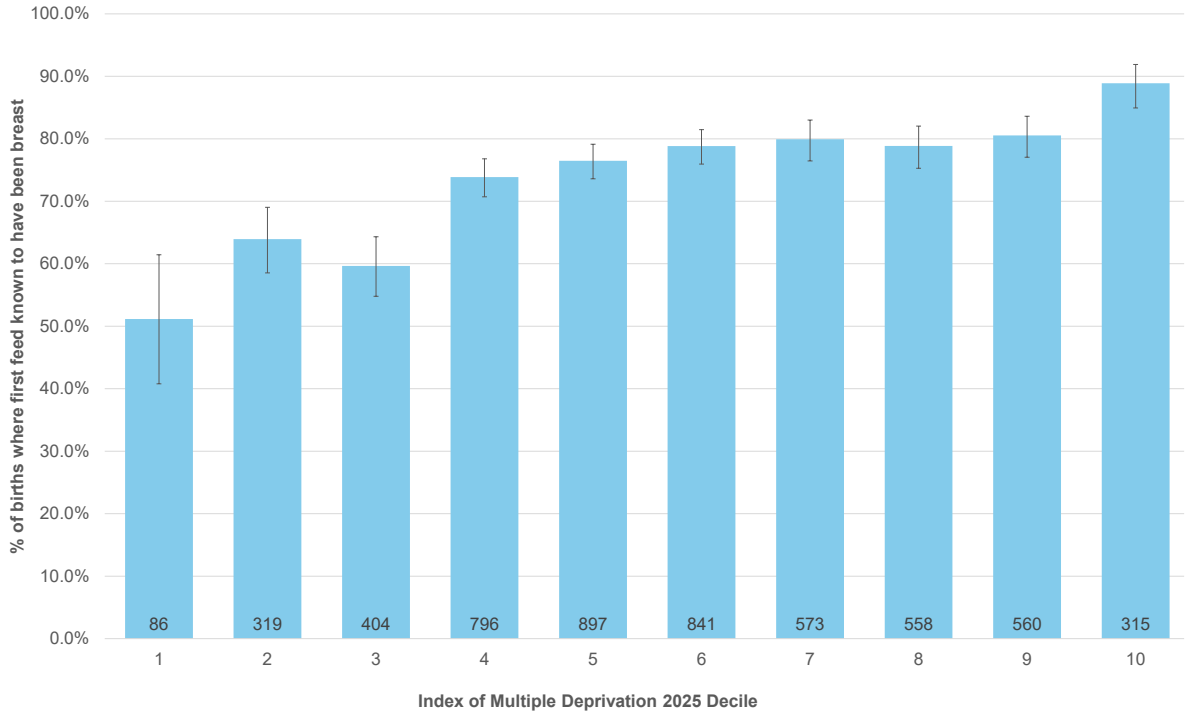
In looking at the three most recent years combined, there were higher rates of breastfeeding among older mothers, with the rates significantly lower than Shropshire in the under 20s (52.8%), the 20-24 age group (57.5%) and the 25-29 age group (72.2%), while rates in those aged over 30 were over 81% and as high as 86.3% in the 35-39 age group.

Percentage of deliveries where babies first feed was breast, by age-group, 2022/23 to 2024/25. Source: SATH Maternity Database



There are also significantly lower rates as deprived increases, with the most three deprived national deciles significantly below the Shropshire figure, including just 51.2% in the most deprived decile, whilst the least deprived decile had a rate significantly above all others at 88.9%.

Percentage of deliveries where babies first feed was breast, by National IMD2025 Decile, 2022-23 to 2024-25. Source: SATH Maternity Database



Domestic violence

According to the women's aid's toolkit for domestic abuse specialists "supporting women and babies after domestic abuse"Error! Bookmark not defined., Domestic abuse is a gender-based form of violence and control. Women and children are its most frequent and intensely impacted victims. Domestic abuse includes physical attacks (e.g. threats of violence, hitting, punching, pushing, throttling, use of weapons), emotional and verbal abuse (e.g. belittling, manipulating, gaslighting), financial control, and social isolation.

Research and practice in the domestic abuse field has tended to focus on the impact on adult victims (usually women) and how we can best support them. In recent years there has also been a growing recognition of the harm children experience when domestic abuse occurs. Perpetrators have received a lot less attention until very recently, and can often seem quite invisible in both research and practice in domestic abuse. When considering the impact of domestic abuse on children, women come under a lot of scrutiny. Abusive men as fathers are largely ignored, whilst women who are victim-survivors and mothers are intensely monitored, advised, and regulated. This can result in mother blaming for women who are struggling with the impact of domestic abuse on themselves, on their baby, and on their relationship with their baby. It is important to note, that abusers may not always be the father of the children, and could be other carers. Abuse can also occur in same-sex relationships. This toolkit focuses on the mother-infant relationship. However, throughout the toolkit we will also ensure that the abusive perpetrator does not slip out of view. We hope by doing this, we will provide a set of materials that are truly woman centred and infant centred. Research and practice has increasingly focused on the impact of domestic abuse on children, and it has become clear that children and young people can experience significant harm to their emotional wellbeing, their school life, and their relationships. Parents and professionals often assume that because babies are pre-verbal they are less aware of the violence and abuse taking place in their home, and are less likely to be negatively affected. Unfortunately, this is not the case, and recent research suggests that children who experience domestic abuse as babies are more likely to experience negative outcomes than older children.

For some women, domestic abuse begins or escalates when women are pregnant or have very small children. Abusers will often increase their controlling and emotionally abusive behaviours during this time, and there is also a higher risk of physical violence. Abuse during pregnancy can have health and wellbeing implications for both mother and child. Recent research has also highlighted that babies are particularly vulnerable to experiences of domestic abuse, because of the impact of violence and abuse on the relationships that are most important to infant development. Despite this, support for babies and mothers has often been a neglected area in both research and practice. The toolkit aims to fill some of that gap.

KEY POINTS

Effects of domestic abuse on women and babies during pregnancy

For women

- Physical health can be affected, as a result of physical injury, or the risk of worsening existing health problems. Domestic abuse can also trigger chronic pain conditions.
- Stress and mental health difficulties can be triggered or worsened.
- Abuse can impact on women's self concept as parents, and challenge their confidence in their parenting competence and their ability to love and protect their child.
- Domestic abuse can also impact women's image of the baby, impacting on bonding.
- Where reproductive control has been exerted, this can impact severely on women's wellbeing, and on their bonding with their baby.

For babies

- Risk of physical injury and death.
- The stress of domestic abuse can raise cortisol levels, impacting neural development, and emotional wellbeing.
- This may have a long-term impact on babies' development, and can sensitise them to difficulties in managing their own stress once they are born, and as they grow and develop.
- It is important to remember that many babies and children recover well, and that the neurodevelopmental account is only a partial explanation.

The OHID fingertips profiles do not contain any indicators related to domestic violence in pregnancy. However, local information was obtained from the SATH maternity department[30]. This revealed there were 71 women recorded on the maternity database who went on to deliver with a 'Yes' response when asked about domestic violence in the financial years 2022-23 to 2024-25. Besides the age of the mother, there was little other information collected that would allow any analysis and age bands have been combined due to the small numbers. While cases in the 25-29 age group (31%) accounted for a higher percentage of all the domestic violence cases, when compared with the actual number of women who delivered at SATH in those three years by the same age groups, domestic violence was noted in 1.4% of the 1,573 mothers in the 25-29 age group. However, while there were only 6 cases of domestic violence in mothers aged under 20, this is would equate to 3.4% of the 178 deliveries in this age group shown.

Domestic violence indicator by age of mother, 2022-23 to 2024-25. Source: SATH maternity database

	< 20	**20-24**	**25-29**	**30-34**	**35+**	**Total**
Domestic violence number	6	16	22	18	9	**71**
Percentage of domestic violence	8%	23%	31%	25%	13%	
Total number of mothers who delivered	178	680	1573	1974	1099	5504
Domestic violence as a percentage of all mothers	3.4%	2.4%	1.4%	0.9%	0.8%	1.3%

[30] Information request regarding domestic violence in maternity, SATH maternity database

The women's aid's toolkit for domestic abuse specialists "supporting women and babies after domestic abuse"**Error! Bookmark not defined.** states that prevalence studies from a number of countries suggests some concerning statistics as show below. If those statistics were applied to the number of deliveries at SATH in the financial years 2022-23 to 2024-25, where there were 5,504 deliveries, then that would equate to 1,100 to 1,651 women in Shropshire, having suffered physical violence in the last 3 years.

Of pregnant women	**Incident reported**
20-30%	report incidents of physical violence
36%	experience verbal abuse during pregnancy
14%	report very severe or life-threatening violence
20%	subjected to sexual violence
Of pregnant abused women	**Incident reported**
40%	Report to healthcare settings had head and neck injuries
28%	Had broken bones or muscular injuries
34%	Reported being choked

Alcohol and Substance Misuse

Modifiable risk factors in pregnancy can have health impacts on both mother and child. At booking appointment midwives will ask questions and perform tests to ascertain these risks and advise on recommended actions.

Alcohol is a 'teratogen', which means that it can affect foetal development and cause birth defects or complications during pregnancy.

Foetal alcohol spectrum disorder (FASD) is an umbrella term for conditions that can occur in a person whose mother consumed alcohol during pregnancy. The most severe form is known as foetal alcohol syndrome (FAS). Whilst FASD is less severe than FAS, it can result in physical, mental and behavioural problems including learning disabilities which can have lifelong effects. The risk of such problems is likely to be greater the more you drink.[31]

CMOs' Guidance:
The Chief Medical Officers' guideline is that:
•If you are pregnant or think you could become pregnant, the safest approach is not to drink alcohol at all, to keep risks to your baby to a minimum.
•Drinking in pregnancy can lead to long-term harm to the baby, with the more you drink the greater the risk.
The risk of harm to the baby is likely to be low if you have drunk only small amounts of alcohol before you knew you were pregnant or during pregnancy. If you find out you are pregnant after you have drunk alcohol during early pregnancy, you should avoid further drinking. You should be aware that it is unlikely in most cases that your baby has been affected. If you are worried about alcohol use during pregnancy do talk to your doctor or midwife.[32]

[31] Public Health England. The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review. PHE 2016.
[32] UK Chief Medical Officers' Low Risk Drinking Guidelines, 2016

The effects of different drugs of misuse during pregnancy are broadly similar and are largely non-drug specific. Intra-uterine growth retardation and pre-term deliveries contribute to increased rates of low birthweight and increased perinatal mortality[33]. In the UK, around 3% of stillbirths and 2% of neonatal deaths are drug misuse-related and 12% of maternal deaths 6 weeks to 1 year post pregnancy are caused by alcohol/drugs[34] [35]. Higher rates of early pregnancy loss and third-trimester placental abruptions appear to be major complications of maternal cocaine use. Increased rates of stillbirth, neonatal death and sudden infant death syndrome are found in women who misuse cocaine. Women who misuse heroin have a higher rate of small for gestational age (SGA) babies and pre-term delivery, even when allowing for other confounding factors. People who misuse drugs are also more likely to misuse alcohol. 18% of opiate users and 54% of non-opiate drug users in treatment also have alcohol use disorders. Alcohol can also affect foetal development and cause complications during pregnancy or birth defects, including Foetal alcohol spectrum disorder (FASD). Parental drug (and alcohol) use and co-sleeping are established risk factors for sudden infant death syndrome (SIDS).

Women who misuse drugs may not use general health services—due to guilt and fear that children's services will be involved—until late into pregnancy and this increases the health risks for both the mother and child [36]. However pregnancy may act as a strong motivation for women who misuse drugs to reduce or stop their drug use and, where appropriate, to engage in specialist drug treatment. It is important that midwives recognise this opportunity and offer non-judgemental, person-centred support and reliable information about the effect of drug use on their child(ren) to their patients.

The national clinical guidelines on drug misuse and dependence and other key clinical guidance make the case for early identification and intervention[37]. Women who attend drug treatment services, even those who continue to use illicit drugs, usually have better antenatal care and better general health than women who are not in treatment. Therefore, services are advised to fast-track pregnant women into drug treatment to allow for the earliest engagement possible. Outcomes in opioid-dependent pregnant women are better, both in terms of the pregnancy and the child, for women who enter opioid substitute treatment programmes during pregnancy and cease illicit drug use, than for those who do not. Engagement of partners who misuse drugs in treatment is also important to reduce any impact of the partner's drug use on the child(ren) and family's well-being.

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[33] Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group, *Drug misuse and dependence UK guidelines on clinical management* https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management

[34]2015-17 https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Perinatal%20Mortality%20Surveillance%20Report%20for%20Births%20in%202017%20-%20FINAL%20Revised.pdf

(3) 2015-17 https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202019%20-%20WEB%20VERSION.pdf

[35] 2015-17 https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202019%20-%20WEB%20VERSION.pdf

[36] Bell J & Harvey-Dodds L (2008) Pregnancy and injecting drug use. *British Medical Journal*, 336(7656): 1303-1305

[37] NICE. (2010) CG110 *Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors* https://www.nice.org.uk/guidance/cg110; World Health Organisation (WHO) (2014) *Guidelines for the identification and management of substance use and substance use disorders in pregnancy.* Geneva: World Health Organization https://www.who.int/substance_abuse/activities/pregnancy_substance_use/en/

The percentage of pregnant women who self-reported drinking alcohol at the time of booking appointment with midwife was included in previous versions of the OHID profile for pregnancy and birth, however, only for England in 2018/19 and in this 38.9% of all records did not have a valid value for the data item needed for this indicator, and therefore no analysis was produced for local authorities. Instead, some imputation was applied to the dataset based on other observations which came up with a figure of 4.1% of women who were currently drinking at the time of their booking appointment.

Local data from the SATH maternity unit did though include self-reported data on the units of alcohol the mother drunk before pregnancy and also post pregnancy. To ensure there is no risk of identification, 3 years of maternity data was combined (2022-23 to 2024-25) is shown in the table below, although around 26% of records did not have this recorded pre-pregnancy and 24% post-pregnancy. Of those where alcohol was recorded, in this period 46.7% of women were apparently consuming no alcohol pre-pregnancy, with 3.1% (127 women) drinking over the recommended weekly 14 units. At the booking appointment, 99% were not consuming any alcohol, with 0.8% having 1 to 14 units and just 5 women having over 14 units.

Alcohol units' pre-pregnancy and at booking, for women that delivered at SATH, 2022/23 - 2024-25. Source: SATH maternity database

	Alcohol pre-pregnancy		**Alcohol post-pregnancy**	
Self-reported alcohol units	**Number of women**	**% of women**	**Number of women**	**% of women**
0	1908	46.7%	4156	99.0%
1 to 14 units	2055	50.2%	35	0.8%
14 units or more	127	3.1%	5	0.1%
Total recorded	**4090**	**74.3%**	**4196**	**76.2%**
Not recorded	1414	25.7%	1308	23.8%
Total	5504	100.0%	5504	100.0%

Local data from the SATH maternity unit did though include self-reported data on the drug use of the mother at booking. Due to small numbers, 3 years of maternity data was combined (2022-23 to 2024-25) and in this period just 50 (0.9%) of women indicated using drugs at booking and of these, 41 (82%) had a drug referral accepted.

Drugs at booking, for women that delivered at SATH, 2022-23 and 2024-25. Source: SATH maternity database

Drugs at booking	**Number of women**	**% of women**
(blank)	5,454	99.1%
Yes	50	0.9%
Total	5,504	100.0%

In addition to this, data on pregnant women in accessing treatment was provided by the Shropshire recovery partnership who are the commissioned provider for alcohol and substance misuse treatment in Shropshire. Between April 2016 and October 2024, 64 pregnant women from Shropshire were referred and offered appointments about these issues and 56 of them had been discharged.

Of these 64 pregnant women, about a third were under treatment for non-opiates, with just under a third for opiates, and just under a fifth for alcohol, and another fifth for alcohol and non-opiates. Of the total pregnant women, the housing status of them was unknown in half, while 27% had no home of their own (living with family, friends, temporary housing, squatting, supported accommodation or rough sleeping), and 23% were living in a rented

home (social or private landlord). Two thirds of pregnant women were recorded as having mental health needs, while 19% of women had some history of ever suffering domestic abuse – 3 of which were currently subjected to it and 1 of which was currently perpetrating it.

Substance Misuse cohort, for pregnant service users accessing treatment, April 2016 to October 2024. Source: Shropshire Recovery Partnership Database

Substance Cohort	Number of women	% of women
Alcohol	12	18.8%
Alcohol and Non-Opiate	12	18.8%
Non-Opiate	21	32.8%
Opiate	19	29.7%
Total	**64**	**100.0%**

Substance Misuse cohort, for pregnant service users accessing treatment, April 2016 to October 2024. Source: Shropshire Recovery Partnership Database

Substance Cohort	Number of women	% of women
No home of their own	17	26.6%
Rented home only	15	23.4%
Unknown	32	50%
Total	**64**	**100.0%**

Mental Health need, for pregnant service users accessing treatment, April 2016 to October 2024. Source: Shropshire Recovery Partnership Database

Mental Health Needs	Number of women	% of women
Yes	42	65.6%
No	18	28.1%
Unknown	4	6.3%
Total	**64**	**100.0%**

Domestic Violence status, for pregnant service users accessing treatment, April 2016 to October 2024. Source: Shropshire Recovery Partnership Database

Domestic Violence Status	Number of women	% of women
Service User Ever Subjected to Domestic Violence Abuse	12	18.8%
Service User Currently Subjected to Domestic Violence Abuse	3	4.7%
Service User Ever Perpetrated to Domestic Violence Abuse	0	0.0%
Service User Currently Perpetrated To Domestic Violence Abuse	1	1.6%
Any recorded domestic violence (subject or perpetrated)	**12**	**18.8%**
Total	**64**	**100.0%**

Mental health

There were a large number of mental health risk factors noted on the maternity database, this included current or past depression, previous postal natal depression, self-harm, anxiety, eating disorder, bi-polar, previous suicide attempts, those actively under care of secondary mental health services and those with a family member with a serious mental health condition. In total, 2,088 (37.9%) had one of these conditions.

Mental health involvement status, for women that delivered at SATH, 2022/23 to 2023/24.
Source: SATH maternity database

Any Mental Health Risk Factor listed	Number of women	% of women
No	3,416	62.1%
Yes	2,088	37.9%
Total	5,504	100.0%

Mental health feelings reported, for women that delivered at SATH, 2022/23 to 2023/24.
Source: SATH maternity database

Mother answered yes to	Number of women	% of women
Feeling down depressed or hopeless	494	9.0%
Not Feeling supported	39	0.7%
Feeling little interest / pleasure in doing things	373	6.8%
Is Help Required with Feelings	167	3.0%
Total	5,504	100.0%

Family Nurse Partnership

In the last 3 periods (years ending 1/10) the Shropshire family nurse partnership (FNP) has worked with 137 clients, while the national FNP has worked with nearly 6,500 clients. The national FNP database allows comparisons between Shropshire and nationally, which are shown on the tables below. Shropshire has a low percentage of clients on intake than national that were aged under 17 at enrolment, and a lower percentage of clients that were aged 20 or over. When looking at the client's characteristics and vulnerabilities, the clients in Shropshire compared to England had slightly better living arrangements, were more likely to have completed school and had better educational and vocational qualifications and skills, be in education, education or training, were more likely to be with the child's biological father and were not as reliant on benefits for their entire household income.

Age of clients at enrolment on Family Nurse Partnership, 3-year period ending 1st October 2024. Source: Family Nurse Partnership Database, NES Data team

Age at enrolment	**Shropshire %**	**National %**
<16 years	4.4%	6.6%
16	6.6%	11.4%
17	19.7%	19.0%
18	35.8%	25.5%
19	26.3%	22.3%
20	7.3%	8.6%
>20	0.0%	6.6%

Client characteristics and vulnerabilities at intake on Family Nurse Partnership, 3-year period ending 1st October 2024. Source: Family Nurse Partnership Database, NES Data team

Client's characteristics at enrolment	**Shropshire %**	**National %**
White ethnicity	94.4%	75.1%
Living arrangements: Do not live with parents, partner or other family members	10.3%	12.7%
Living arrangements: Homeless	0.0%	3.7%
Completed school	88.1%	68.6%
Clients who lived away from home aged 18 and under	29.4%	34.5%
Clients with academic or vocational qualifications	66.7%	52.2%
Low mastery	13.7%	20.7%
Clients in education, employment or training (EET) - only those aged 16 or over	54.1%	37.9%
Parter at intake is child's biological father	97.1%	64.0%
Benefits account for all income in client household (excludes those who prefer not to say)	22.6%	28.3%

In terms of client's vulnerabilities at intake, the clients in Shropshire on the FNP had higher levels of moderate to severe anxiety and depression in pregnancy than England, however, the percentage of clients who had ever received mental health services before enrolling, and who had ever received mental health services currently was lower than national. Alcohol use in the last 12 months was higher in Shropshire than nationally, and more in Shropshire were smokers in pregnancy (39%) when they were enrolled in the FNP programme. But, overall, the clients in Shropshire were in better general health than national and there were less clients who had long standing illness.

Client characteristics and health vulnerabilities at intake on Family Nurse Partnership, 3-year period ending 1st October 2024. Source: Family Nurse Partnership Database, NES Data team

Client's characteristics at enrolment	Shropshire %	National %
Moderate to severe anxiety in pregnancy	30.2%	11.4%
Moderate to severe depression in pregnancy	14.0%	9.5%
Clients ever receiving mental health care services before enrolment	15.1%	29.7%
Clients ever receiving mental health care services at intake (current)	7.1%	13.3%
Clients with learning difficulties	2.4%	7.3%
Clients consumed alcohol in past 7 days	0.0%	0.8%
Clients consumed alcohol in past 12 months	69.4%	47.0%
Cannabis use	1.6%	2.6%
Other drug use	0.0%	0.2%
General health - excellent	19.4%	12.5%
General health - good	66.9%	59.6%
General health - fair	12.9%	14.6%
General health - poor	0.8%	1.2%
Smoking in pregnancy	39.0%	33.5%
Long standing illness	12.9%	19.0%

The outcomes for clients on the FNP programme in the last 3 years are very positive for Shropshire when compared to the national programme, Shropshire had lower figures for full term infants who were a low birth weight and lower figures for premature infants. Smoking was a particular highlight as Shropshire had 97.1% of clients who were from a smoke-free household, compared to 78.1% nationally. This is particularly impressive as 39% of Shropshire FNP clients were smoking in pregnancy at intake, and in the general pregnant population in Shropshire the smoking status at time of delivery figure for 2023-24 was 9.9%. Meanwhile the breastfeeding figures for Shropshire's FNP clients are higher than national FNP clients both at birth and at 6 weeks after.

Child Outcomes for Clients on Family Nurse Partnership, 3-year period ending 1st October 2024. Source: Family Nurse Partnership Database, NES Data team

Child birth outcomes	Shropshire %	National %
Low birth weight in full term infants	2.6%	1.4%
Premature infants	7.6%	9.5%
Breastfeeding exclusively new birth	29.4%	22.7%
Breastfeeding exclusively 6 weeks after birth	18.2%	14.7%
Ever received breastmilk - new birth	65.4%	50.6%
Currently receiving breastmilk - 6 weeks after birth	30.3%	28.7%
Smoke free household - new birth	97.1%	78.1%

Case study

Amy is 18 years old and has had psychosis and long periods of depression and anxiety due to childhood trauma, two sexual assaults in her early teens and a history of self harm. She lives at home with her Mum and 2 sisters until very recently. Her partner Tommy is also 18 years old and has anxiety. Amy witnessed DV to her mother for most of her childhood. Her father was imprisoned for actual bodily harm and drug dealing. He was released and is now back in prison after a serious physical assault on his recent partner. Amy lives in a small village in Shropshire where she was born. Amy has Daisy who is now 2 years old.

Pregnancy

Amy was stable during pregnancy and did not want referral to the perinatal mental health team.

No self harm or suicidal thoughts.

Good engagement with the Family Nurse was key to develop a trusting relationship and work through challenges

Developing and promoting self efficacy.

Amy was keen to breastfeed

Both Amy and Tommy wanted to stay together for their in-born baby and worked hard at maintaining a healthy relationship.

Focus of work was encouragement to access support from mental health services, domestic abuse and preparation for parenthood.

Infancy

Born full term

Amy started to struggle very early on in pregnancy and perinatal team became involved.

Focus—self efficacy, modelling good engagement and reflecting on positive relationships and their benefit.

Intensive work began with mental health team and medication commenced.

Accessed MIMS course her FN was facilitating.

Amy engaged well although was often worried about how she would be judged until she realised she could trust her FN.

Consistent work with Family Nurse Partnership and use of Parents in Parenting Education (PIPE) and DANCE tools.

Fully breastfed Daisy for 6 weeks.

Mother accessing baby groups locally and Daisy going to nursery.

Update

Mum and Daisy have an excellent attachment

Amy now no longer requiring mental health services and medication reducing.

Passed her fashion design course at college with distinction and has started university studying for a degree.

Helps support other young mums.

Amy has moved into their own flat recently

Tommy and Amy are continuing to work on their relationship and co parent Daisy.

Amy able to manage her self independently.

Daisy happy and thriving.

Achieving high ASQ scores particularly in communication and social and emotional.

ASQ SE score shows Amy and Daisy to have a good attachment.

Mum coping well at home and feels less isolated.

Graduates next month.







Impact & Potential Savings:

Intensive support and education with attachment, stimulation and play for Daisy.

Mental health and healthy relationship work undertaken as part of the FNP programme and personalisation.

Amy's deterioration in her mental health may not have been assessed so rapidly if she were in universal services as she didn't voluntarily seek help.

Access to college and studying.

Amy able to see that relationships that her Mum had had were destructive ones and able to separate herself away from it and concentrate on Tommy and protect the relationship.

Work with AXIS after referral from myself for counselling and support following previous sexual assaults.

Engagement with and reflection on healthy relationships may lead to reduced exposure to domestic violence and enable Amy to be better able to model good relationships to her daughter.

Long acting reversible contraception = less chance of further unplanned pregnancy.

Excellent multi agency working.

Recommendations

Recommendations are based on the Areas of Need

1. To continue to monitor and reduce teenage conception rates
2. To increase the number of women who are booked by midwifery within the first 10 weeks of pregnancy
3. To continue to ensure that throughout pregnancy and giving birth, parents receive appropriate personalised care for their individual needs so that we are responsive to equality, diversity and inclusion.
4. To improve data collection of modifiable risk and vulnerability factors during pregnancy – to include excess weight, smoking status at booking, alcohol consumption, drug use, folic acid supplement use, healthy start vitamins, mental health, domestic abuse and neurodivergence and physical and learning disabilities.
5. To increase the rates of vaccination in pregnant women against influenza and pertussis
6. To increase access to services to support healthy pregnancy within local communities
7. To look into and address concerns raised where there are repeat pregnancies and where children become looked after within the same family unit
8. To support partners / family members of **pregnant women to stop smoking** and to reduce the rates of pregnant women smoking at time of delivery.
9. To increase breastfeeding initiation rates, to achieve World Health Organisation Baby Friendly Initiative (BFI) accreditation
10. To continue to monitor and improve **infant mortality and stillbirth rates**, by addressing modifiable factors such as maternal obesity, smoking, safer sleeping, parenting support etc.
11. To monitor levels of referrals for early help from midwifery to ensure appropriate early support is provided to reduce the risk of escalation to statutory children's social care.

Area of need	Mitigation (What are we doing now?)	Recommendation (What are we intending to do and how?)	Governance (Where does this recommendation sit?)
1. To continue to monitor and reduce teenage conception rates further	Family Nurse Partnership RSE Education in Schools Sexual Health Service VCSE support through SYA School nursing service provide access to emergency contraception and condom distribution scheme	Increase availability and uptake of LARCs Review options to increase awareness of RSE for young people Development of Youth Strategy & Partnership Development of closer working relationships between sexual health services and school nursing and family nurse partnership	Public Health Youth Partnership
2. To increase the number of women who are booked by midwifery within the first 10 weeks of pregnancy	Self-referral into midwifery booking system	Raising awareness of the self-referral system LMNS to monitor appropriate KPIs	LMNS
3. To continue to ensure that throughout pregnancy and giving birth parents receive personalised care for their individual needs and responsive to equality, diversity and inclusion.			
4. To improve data collection of modifiable risk and vulnerability factors during pregnancy – to include excess weight, smoking status at booking, alcohol consumption, drug use, folic acid	Gaps in data collection which make it difficult to ensure services are providing early support throughout pregnancy	Improved data collection through maternity service at booking or early pregnancy.	LMNS

Area of need	Mitigation (What are we doing now?)	Recommendation (What are we intending to do and how?)	Governance (Where does this recommendation sit?)
supplement use, healthy start vitamins, mental health, domestic abuse and neurodivergence and physical and learning disabilities.			
5. To increase the rates in pregnant women of vaccination against influenza and pertussis	Healthy Pregnancy Team Raising awareness	Learning from the vaccination bid educator role to inform future actions Continue to raise awareness directly to prospective parent and through front-line practitioners including GPs	Health Protection Quality Assurance Board ICB System Quality Board
6. To increase access to services to support healthy pregnancy within local communities	Women's Health Hubs (WHHs) Community & Family Hubs (CFHs) Digital Offers	Review potential to increase digital offers Continued roll out and effective delivery of WHHs and CFHs	ShIPP HWBB LMNS
7. Concerns regarding levels of repeat pregnancies where children become looked after within the same family unit	Potential area of need to be further scoped as raised by safeguarding leads	To undertake a deep dive into needs of families who have repeat babies and 0-4s becoming children looked after To present the finding to children's safeguarding board with recommendations around appropriate interventions and support to disrupt the cycle. To review evidence of best practice and delivery models.	To be agreed

Area of need	Mitigation (What are we doing now?)	Recommendation (What are we intending to do and how?)	Governance (Where does this recommendation sit?)
		To develop a hope box service for women whose babies are removed from their care at birth – guidelines in progress, as this is a nationally recognised service that research has shown reduces the number of repeat births and improves the women's emotional, mental and maternal health	
8. To support partners / family members of **pregnant women to stop smoking** and to reduce the rates of pregnant women smoking at time of delivery.	Healthy Pregnancy Team SaTH which provides individualised stop smoking support.	To increase uptake of women and family members stopping smoking during pregnancy and time of delivery. To ensure pre-conception advice to parents promotes stop smoking provision. To increase the number of women undertaking CO monitoring throughout pregnancy	LMNS for pregnancy provision Public Health for community offer HWBB
9. To increase breastfeeding initiation rates, to achieve World Health Organisation Baby Friendly Initiative (BFI) accreditation	Breastfeeding Team in midwifery / SaTH BFI Action Plan in place Tongue Tie service in place	Re-instate breast-feeding and antenatal education Reduce supplementation rates Achieve BFI status	LMNS HWBB
10. To continue to monitor and improve **infant mortality and stillbirth rates**, by addressing modifiable factors such as	Healthy Pregnancy Team CDOP Review	Healthy Lives Service – community to support family members in the home Early Help – increase referrals	LMNS System Quality Group

Area of need	Mitigation (What are we doing now?)	Recommendation (What are we intending to do and how?)	Governance (Where does this recommendation sit?)
maternal obesity, smoking, safer sleeping, parenting support etc.	System Child Mortality Plan Healthy Weight Strategy	Family Foundations course – increase uptake Solihull Approach – antenatal course increase uptake Maternity service – antenatal education	Children's safeguarding Board HWBB
11. To monitor levels of referrals for early help from midwifery to ensure appropriate early support is provided to reduce the risk of escalation to statutory children's social care.	0-5 early help team in place	Midwifery to continue to refer to 0-5 Early Help team and Early Help to monitor referrals. Have robust recording mechanisms for early help interventions across all organisations Narrative around the early Help/best start to life work to inform midwives what is on offer locally, and how to refer early for local support? Meetings to be scheduled for Best start for life and early help support, team to meet CMW's in Shropshire to aid collaborative working with pregnant families	Early help partnership board

END OF REPORT