Shropshire Council

Children and Young People Needs Assessment

Chapter 2: Maternity (Pregnancy and birth)

January 2025

Contents

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 babies, infants and children aged 0-4 across Shropshire. Other chapters are referenced throughout to refer to for certain insights and further information.

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 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:

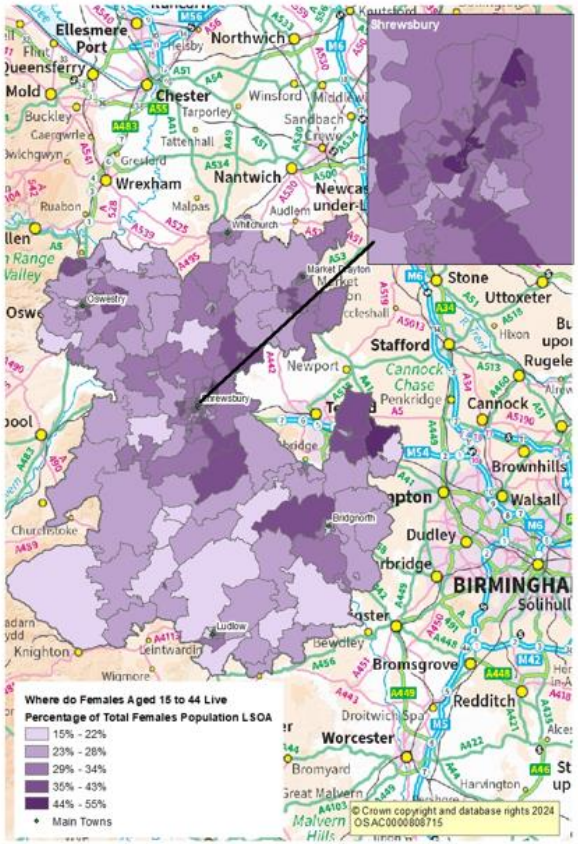
- To describe the population profile of women of child-bearing age - please also see the Population and Context chapter
- To identify risk factors that impact on maternal, infant and child health outcomes - please also see the Population and Context chapter
- To provide an overview of the wider determinants 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



49,755
Females in Shropshire aged 15 to 44 years (2022) a 3.4% fall from 2011

(England 3.5% increase since 2011)

30%
of all Females in Shropshire are aged 15-44 years (15% of the total population Male and Female combined)

(England 38% of the total female population)

2,567 live births Shropshire (2022)

51.6 General Fertility Rate Shropshire (2022) England 51.9

2.2% Under 18s birth rate per 1,000 births Shropshire (2022)

(England 3.4%)

12.5% Under 18s Conception Rate per 1,000 (2021)

(England 13.1%)

66.2% Under 18 Conceptions leading to abortion (2021)

England (53.4%)

11.4% of expectant mothers were smoking at time of delivery in Shropshire (2022/3) (England 8.8%)

14.2% of expectant mothers were smoking in early pregnancy (2018/19) (England 12.8%)

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

51.2% of expectant mothers had early access to maternity care (2018/19) (England 57.8%)

2.1% of term babies had a low birth rate (2022) (England 2.9%)

36.4% of deliveries were by Caesarean (2022/23) (England 37.8%)

68.3 of babies per 1,000 live births, were born premature (before 37 week's gestation (2019 – 21) (England 77.9%)

2.8 per 1,000 births were stillborn (2020-22) (England 3.9)

70.3 Ectopic pregnancy admission rate per 100,000 female population aged 15 – 44 (2022/23) (England 89.0)

15.3 Multiple Births per 1,000 births (2021) (England 13.7)

Doing well

1. Low birth weight of term babies – has been significantly below England for the last 3 years and is the lowest in the West Midlands region

2. Premature births (less than 37 weeks gestation) - has been significantly below England for the last 3 years and is the lowest in the West Midlands region

3. 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

4. Healthy life expectancy at birth (Females) – is significantly above England and is the highest in the West Midlands region

5. Life expectancy at birth (Male) – remains significantly above England and has been in each 3-year rolling period back to 2001-03 and is the second highest in the West Midlands region

6. Life expectancy at birth (Female) - has been significantly below England for the last 3 years 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.

3. Smoking in early pregnancy - Shropshire's performance is significantly higher than both England and the West Midlands and is second highest in the West Midlands region.

4. Obesity in early pregnancy - in the previous method for 2018-19, Shropshire's performance was significantly higher than England, but similar to West Midlands. However, in the new definition for this indicator, there was a data submission error with Shropshire for the last year and the one before

5. Smoking status at time of delivery - Shropshire's performance is higher than the national average as it has been for the three years previous.

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 (to update, this is from the early years chapter at the moment!)

Best Start for Life

The Best Start for life policy is a vision for brilliance in the 1,001 critical days from conception to age 2. Commissioned by the Prime Minister, and chaired by Rt Hon Andrea Leadsom MP, this vision was developed with input from families, professionals and academics.

The vision

The 1,001 critical days from conception to the age of two set the foundations for an individual's cognitive, emotional and physical development. Investing in this critical period presents a real opportunity to improve outcomes and tackle health disparities by ensuring that thousands of babies and families have improved access to quality support and services.

Developed as part of the early years healthy development review, this policy outlines 6 areas for action to improve the health outcomes of all babies in England.[1]:

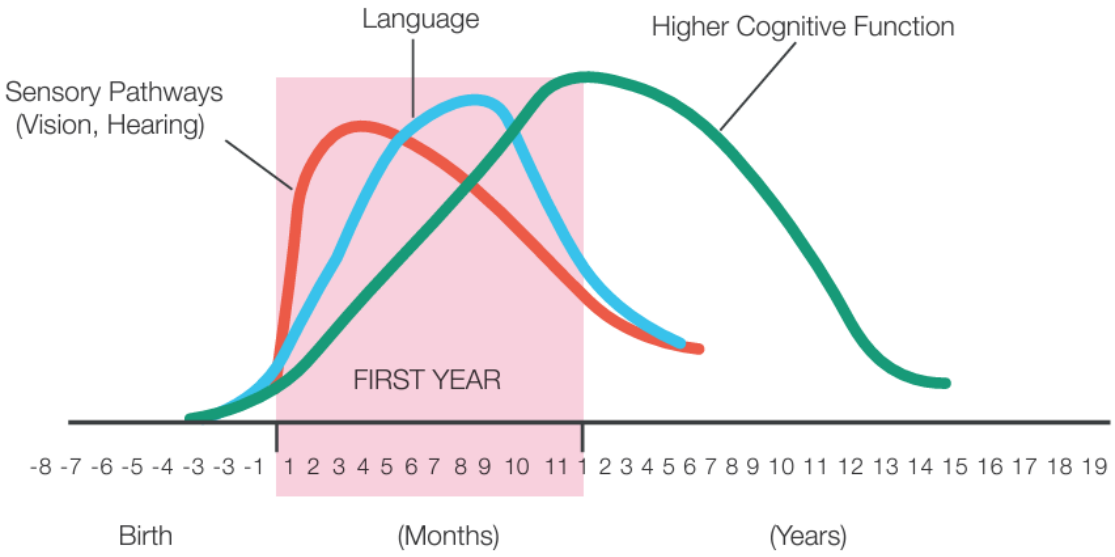
Action Areas

Ensuring families have access to the services they need
1. **Seamless support for families:** a coherent joined up Start for Life offer available to all families.
2. **A welcoming hub for families:** Family Hubs as a place for families to access Start for Life services.
3. **The information families need when they need it:** designing digital, virtual and telephone offers around the needs of the family.
Ensuring the Start for Life system is working together to give families the support they need
4. **An empowered Start for Life workforce:** developing a modern skilled workforce to meet the changing needs of families.
5. **Continually improving the Start for Life offer:** improving data, evaluation, outcomes and proportionate inspection.
6. **Leadership for change:** ensuring local and national accountability and building the economic case.

The policy highlighted the international, evidence-based agreement on the importance of the 1,001 critical days. During this time, our brains lay the foundations for the emotional health, physical wellbeing and social skills needed to live a healthy, happy life.

[1] https://www.gov.uk/government/publications/phe-strategy-2020-to-2025

Figure 1: Human Brain Development from the Center on the Developing Child at Harvard University, available at https://developingchild.harvard.edu/



Research shows that supporting babies' development can lead to lifelong benefits, including increased economic chances, longer life expectancy and reduction in crime.

Providing high quality services and support for babies is not only good for their lifelong potential, it can also reduce demand for public services by responding to risks early. Conversely, not dealing with issues at the earliest opportunity leaves individuals requiring more support later in life. This can be expensive. To give just one example, the Early Intervention Foundation estimated the cost of late intervention to be £17 billion a year in England and Wales.

To help minimise these costs and bring lifelong benefits to babies, Start for Life support must be focused on the right things and be well delivered. There are many services that all families rely on during the 1,001 critical days. These include midwifery, health visiting, infant-feeding support and perinatal mental health and parent-infant relationship support. Some families also require additional help across a range of areas such as smoking cessation, drugs and alcohol support, domestic violence reduction and debt and housing advice. Evidence points to several important areas that particularly impact a baby's health and development and where improvements in services are needed. This includes, but is not limited to, services that support breastfeeding, parent-infant relationships and perinatal mental health [2].

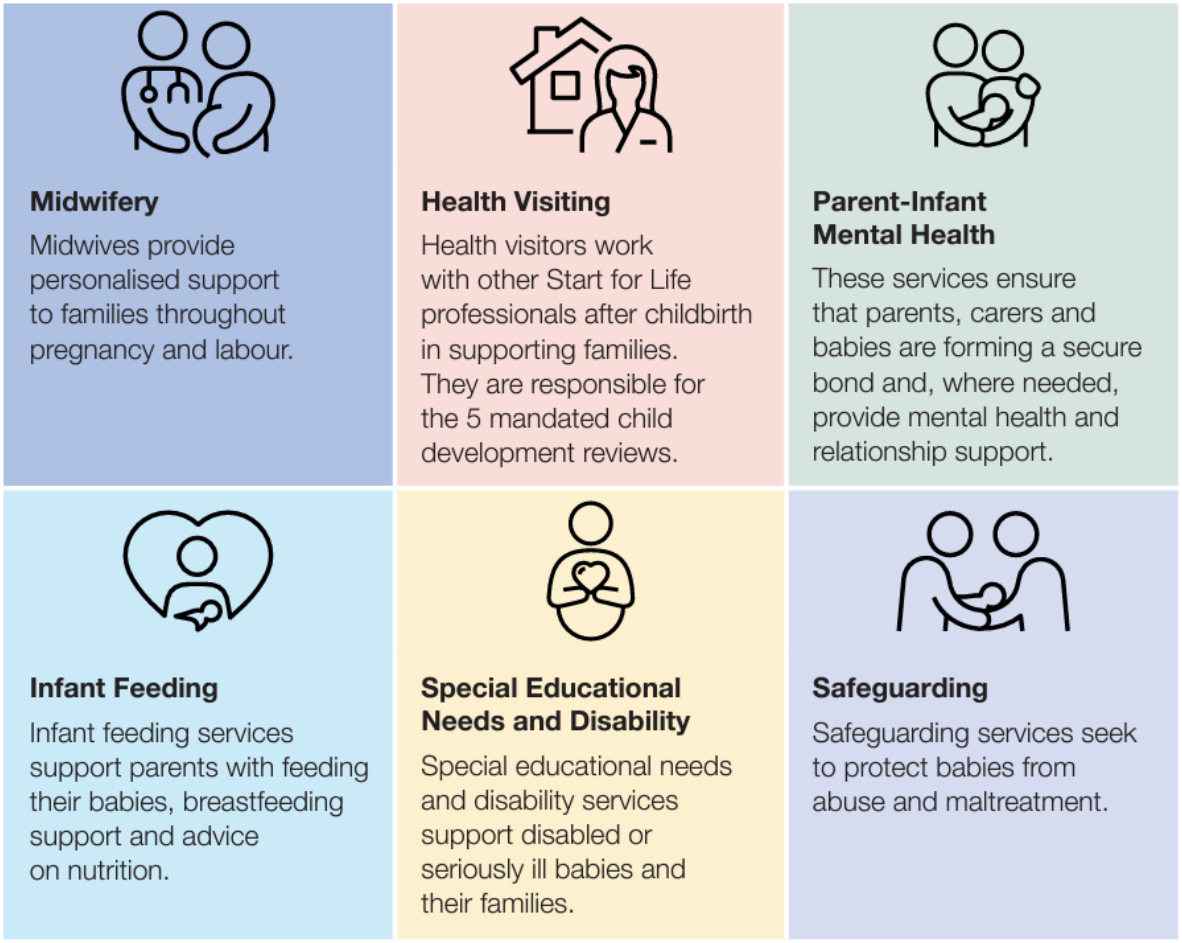
The services that families currently receive.

There are many different services available to support families throughout pregnancy, as their baby is born and in the months that follow. Currently, a small number of services are offered to every new parent or carer – these include midwifery and health visiting services, which sit alongside those services available to everyone, like General Practitioners (GPs) and NHS 111.

[2] Best Start for Life: A Vision for the 1,001 critical days'
https://www.gov.uk/government/publications/phe-strategy-2020-to-2025

Many local partners offer a broader range of services to all their families, but a significant number only offer additional services on a 'targeted' basis in response to need. These additional services include breastfeeding support, mental health support, smoking cessation and intensive parenting support. Local authorities, working with partner organisations and agencies, have a statutory duty to safeguard and promote the welfare of all children, including babies, in their area. All of these services are vital for ensuring every baby gets the best start.

The 6 Universal Start for Life services



Aims

The ambition of Best Start for Life is to help reduce inequalities and improve health outcomes for children and families across England to ensure all mothers experience good health before, during and after pregnancy and all children to have a happy healthy childhood[3].

- reduced rates of infant mortality and low birthweight
- improvements in rates of key protective factors linked to better child health outcomes, such as maternal mental health and breastfeeding
- higher rates of childhood immunisation
- more children ready to learn by the age of two and ready to start school by the age of five

[3] Public Health England's 5-year strategy

- lower rates of tooth decay and hospital attendances due to preventable accidents and illnesses

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[4].

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, 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:[5].

- 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

Good health, wellbeing and resilience are vital for all our children now and for the future of society. There is good evidence about what is important to achieve this through improving children and young people's public health. This is brought together in the national healthy child programme 0 to 19.

[4] Health and Social Care Act 2012
[5] Best Start in life and beyond: healthy child programme 0 to 19

The 0 to 5 element of the healthy child programme is led by health visiting services and the 5 to 19 element is led by school nursing services. Together they provide place-based services and work in partnership with education and other providers where needed. 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 [6].

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

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

Healthy Child Programme: Pregnancy and first 5 years of life

Pregnancy and the first years of life are one of the most important stages in the life cycle. This is when the foundations of future health and wellbeing are laid down, and is a time when parents are particularly receptive to learning and making changes. There is good evidence that the outcomes for both children and adults are strongly influenced by the factors that operate during pregnancy and the first years of life. We have always known this, but new information about neurological development and the impact of stress in pregnancy, and further recognition of the importance of attachment, all make early intervention and prevention an imperative (Centre on the Developing Child, 2007). This is particularly true for children who are born into disadvantaged circumstances[7].

The Healthy Child Programme offers every family a programme of screening tests, immunisations, developmental reviews, information and guidance to support parenting and healthy choices – all services that children and families need to receive if they are to achieve their optimum health and wellbeing.

The Healthy Child Programme is universal in reach. It sets out a range of public health support in local places to build healthy communities and to reduce inequalities. It also includes a schedule of interventions, which range from services for all through extra help to intensive support. The Healthy Child Programme is also personalised in response. All services and interventions need to be personalised to respond to families' needs across time. For most families most of this will be met by the universal offer.

The service model is based on 4 levels of service – community, universal, targeted and specialist, depending on individual and family need. The use of community-based assets is central to the universal offer, where health visitors and school nurses are well placed to identify and signpost to local community support. Contact points or universal health and wellbeing reviews can be utilised to identify needs and to develop a support offer or signpost to specialist services if required.

Effective implementation of the HCP should lead to:

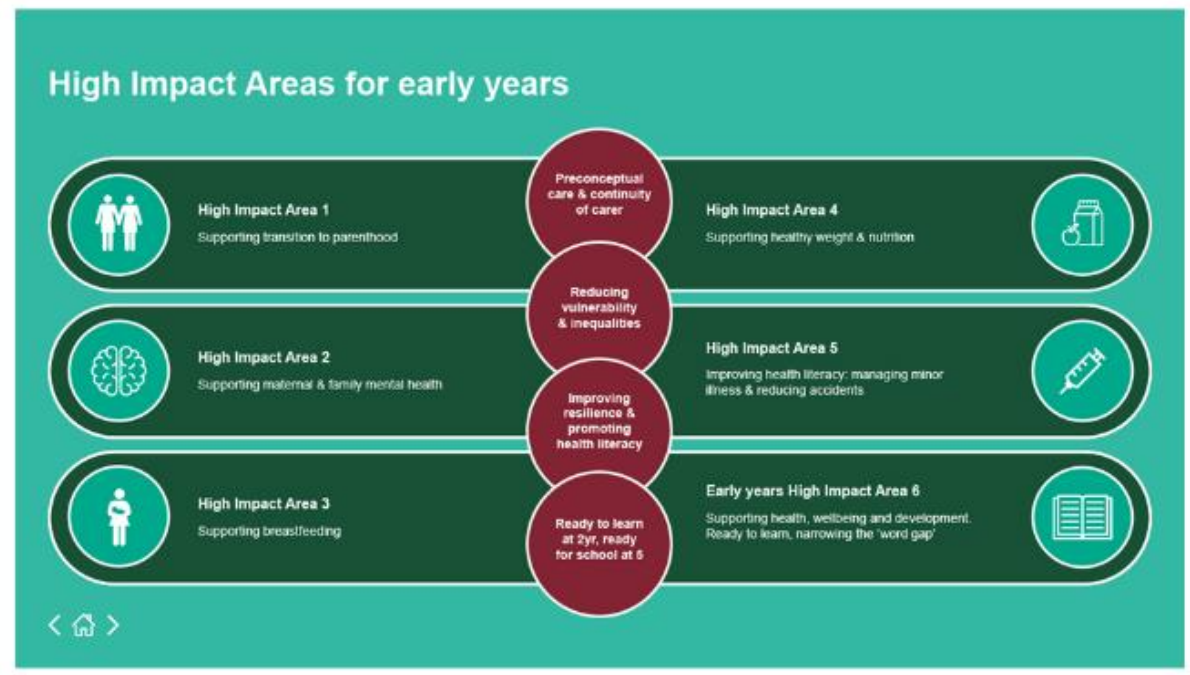
- strong parent–child attachment and positive parenting, resulting in better social and emotional wellbeing among children;
- care that helps to keep children healthy and safe;
- healthy eating and increased activity, leading to a reduction in obesity;
- prevention of some serious and communicable diseases;
- increased rates of initiation and continuation of breastfeeding;
- readiness for school and improved learning;
- early recognition of growth disorders and risk factors for obesity;
- early detection of – and action to address – developmental delay, abnormalities and ill health, and concerns about safety;
- identification of factors that could influence health and wellbeing in families; and
- better short- and long-term outcomes for children who are at risk of social exclusion.

The full schedule of the HCP can be found here.

High impact areas

The high impact areas have been developed to improve outcomes for children, young people and families. They are based on evidence of where these services can have significant impact for all children, young people and families and especially those needing more support and impact of health inequalities[8].
Early years (health visiting and school nursing) high impact areas 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.

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'

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

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 vulnerable young women and their families that 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:

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[9].

- supporting young mothers to build self-efficacy and engage with education, training and employment
- improving child health and development and early education outcomes particularly for boys, children of very young mothers and mothers who are not in education, training or employment
- delivering the Healthy Child Programme to first time young mothers
- helping young parents' access and engage with local services
- identifying safeguarding issues and working alongside statutory services to support interventions

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:

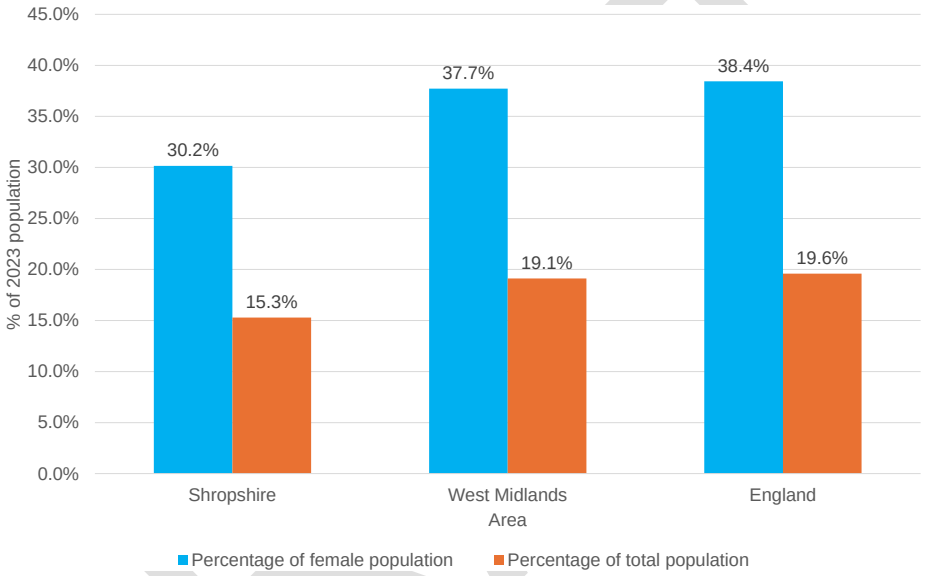
- supporting transition to parenthood and the early weeks
- supporting maternal and infant mental health
- supporting breastfeeding (initiation and duration)
- supporting healthy weight and healthy nutrition
- improving health literacy; reducing accidents and minor illnesses
- supporting health, wellbeing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

[9] 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[10]. 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[11]

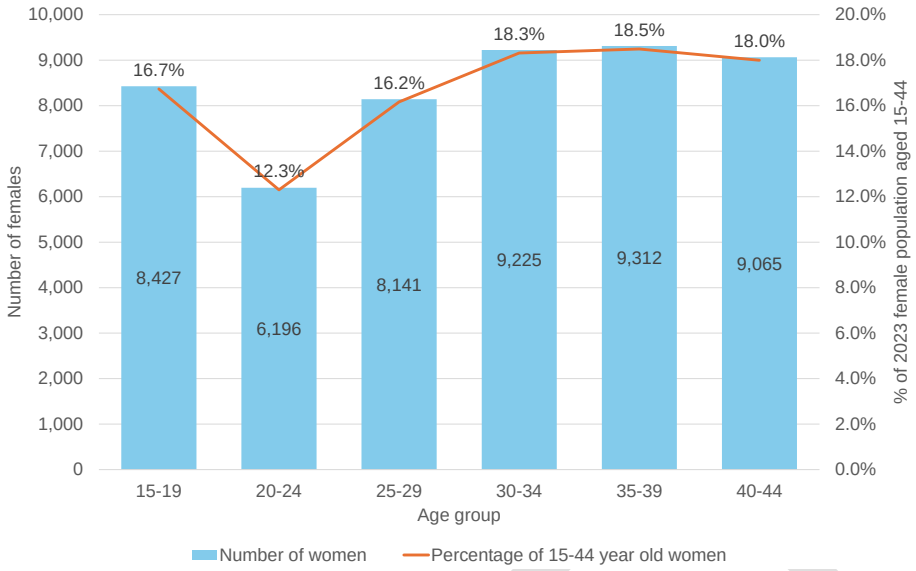
Female population aged 15-44 as a percentage of the total population, by area, 2023 mid-year population estimates. Source: 2023 Mid-year population estimates, ONS



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%).

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

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



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[12]. 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%
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%

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

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%**

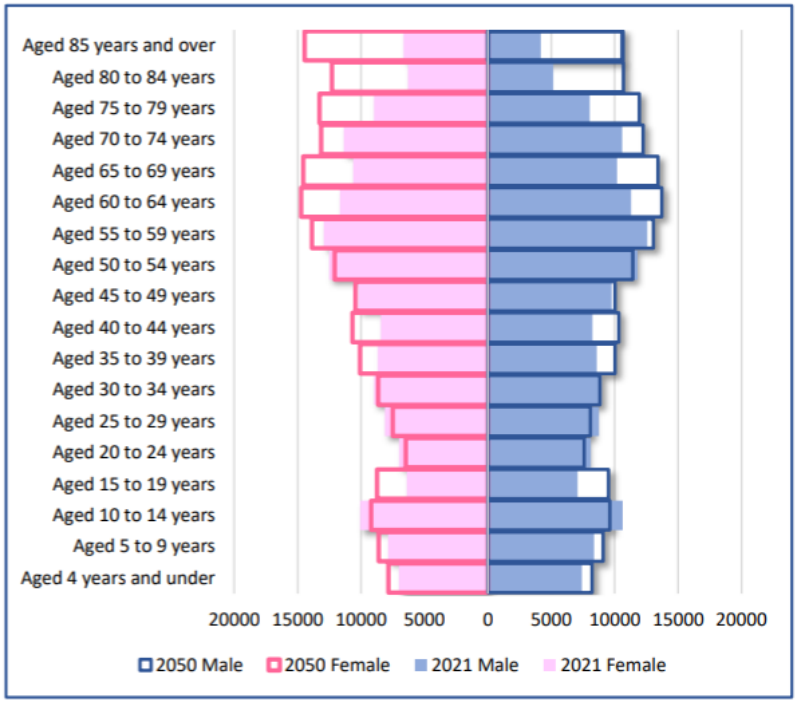
Future trends

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.

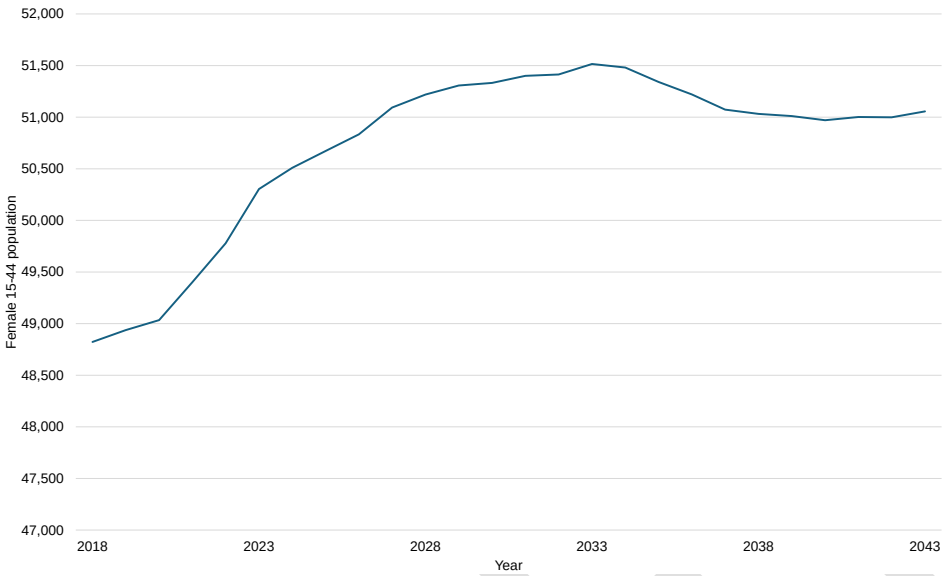
Chart showing population projections Shropshire between 2021 and 2050. Projections are SNPP to 2043, then rolled on to 2050 using PopGroup



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)[13].

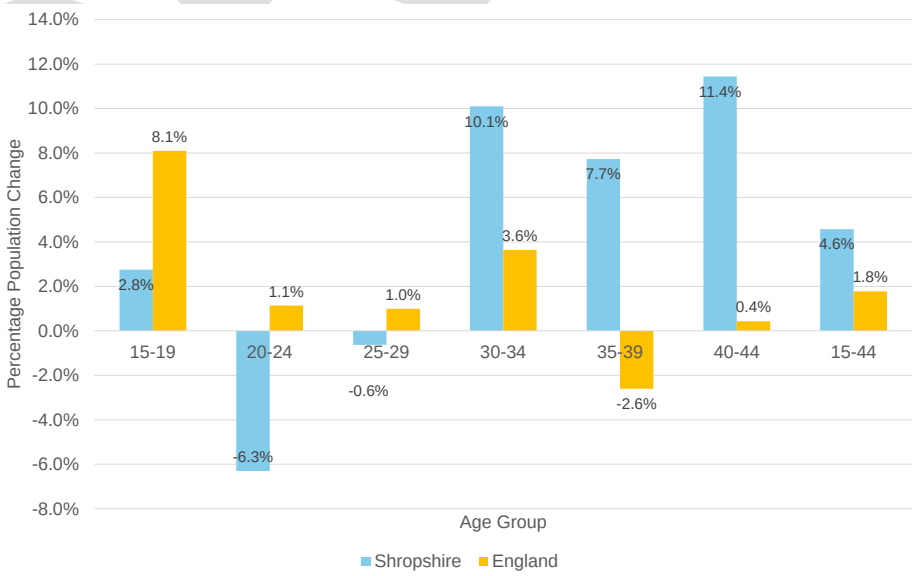
[13] Population projections for local authorities, ONS

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 [14].

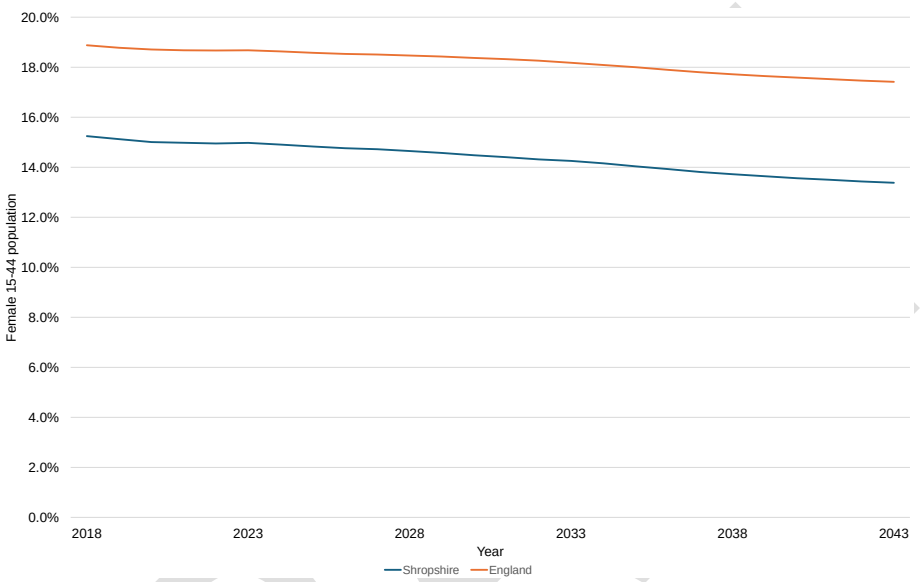
ONS percentage population projections change for 15–44-year-olds in Shropshire and England, 2023-2043, Source: Population projections for local authorities, ONS



[14] 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[15].

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



[15] Population projections for local authorities, ONS

Key statistics

High level summary

The data below presents a range of performance and outcome monitoring measures relating to pregnancy and birth and are in line with assessing outcomes and the success of the Healthy Child Programme[16]:

Indicator	Period	Shropshire			West Midlands	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Percentage of deliveries to women from ethnic minority groups	2022/23	→	10	3.6%*	31.1%	25.3%	2.1%		
General fertility rate	2022	→	2,567	51.6	55.4	51.9	32.2		67.1
Under 18s conception rate / 1,000	2021	→	65	12.5	15.2	13.1	31.5		1.1
Under 18s conceptions leading to abortion (%)	2021	→	43	66.2%	51.4%	53.4%	26.0%		
Early access to maternity care New data	2023/24	→	1,515	58.6%	61.2%	63.5%	16.6%		84.7%
Early access to maternity care (previous method)	2018/19	–	1,425	51.2%	56.8%	57.8%	16.0%		79.1%
Folic acid supplements taken before pregnancy ⚠ New data	2023/24	↓	40	1.5%	8.0%	19.7%	0.5%		
Folic acid supplements before pregnancy (previous method)	2018/19	–	-	31.6%	17.0%	27.3%	-	*Insufficient number of values for a spine chart*	
Smoking in early pregnancy ⚠ New data	2023/24	–	420	18.4%	13.0%	13.6%	-	*Insufficient number of values for a spine chart*	
Smoking in early pregnancy (previous method)	2018/19	–	-	14.2%	14.5%	12.8%	29.1%		2.1%
Obesity in early pregnancy ⚠ New data	2023/24	–	-	*	28.7%	26.2%	-	*Insufficient number of values for a spine chart*	
Obesity in early pregnancy (previous method)	2018/19	–	-	24.1%	25.4%	22.1%	30.5%		
Drinking in early pregnancy (previous method)	2018/19	–	-	-	-	4.1%	-	*Insufficient number of values for a spine chart*	
Drug misuse in early pregnancy (previous method)	2018/19	–	-	-	-	1.4%	-	*Insufficient number of values for a spine chart*	
Smoking status at time of delivery	2023/24	→	231	9.9%	7.8%	7.4%	17.5%		2.8%
Teenage mothers	2022/23	→	-	*	0.8%*	0.6%*	1.9%		0.0%
Caesarean section %	2022/23	↑	100	36.4%*	37.6%	37.8%	60.0%		26.8%
Multiple births New data	2022	→	34	13.4	13.1	14.6	7.6		
Low birth weight of term babies	2022	→	50	2.1%	3.0%	2.9%	5.0%		1.8%
Low birth weight of all babies New data	2022	→	165	6.4%	7.8%	7.2%	10.7%		5.1%
Very low birth weight of all babies New data	2022	→	35	1.4%	1.3%	1.0%	2.0%		%
Premature births (less than 37 weeks gestation)	2019 - 21	–	534	68.3	85.9	77.9	109.8		55.5
Stillbirth rate	2020 - 22	–	22	2.8	4.4	3.9	6.3		2.1
Admissions of babies under 14 days	2022/23	↑	-	*	92.9	84.8	269.9		30.4
Baby's first feed breastmilk ⚠ New data	2023/24	↑	1,720	81.7%	69.7%	71.9%	41.3%		4.3%
Baby's first feed breastmilk (previous method)	2018/19	–	1,675	70.8%	62.5%	67.4%	43.6%		
Breastfeeding prevalence at 6 to 8 weeks - current method	2023/24	–	1,076	*	*	52.7%*	-	*Insufficient number of values for a spine chart*	
Healthy life expectancy at birth (Male)	2018 - 20	–	-	62.8	61.9	63.1	53.5		
Healthy life expectancy at birth (Female)	2018 - 20	–	-	67.1	62.6	63.9	54.3		71.2
Life expectancy at birth (Male)	2020 - 22	–	-	79.8	78.1	78.9	73.4		82.5
Life expectancy at birth (Female)	2020 - 22	–	-	83.9	82.2	82.8	79.0		3
Infectious Diseases in Pregnancy Screening: HIV Coverage	2022/23	–	-	-	99.8%*	99.8%*	-	*Insufficient number of values for a spine chart*	
Sickle Cell and Thalassaemia Screening: Coverage	2016/17	–	-	-	99.1%	99.3%	-	*Insufficient number of values for a spine chart*	

It should be noted that despite this being the most recent profile for pregnancy and birth, several of these indicators use old data from which has not been updated, but where 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.
How these measures relate to the six high impact areas can be found here.

[16] 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 2022, there were 2,567 live births, with a general fertility rate of 51.6 per 1,000, which was similar to the national rate of 51.9, and below the regional rate of 55.4. Shropshire was the second lowest fertility rate in the West Midlands, with only Worcestershire below it, and when compared to Shropshire's five nearest statistical neighbours, Shropshire sits in the middle of them. Shropshire's fertility rate has been similar to England's in the last 3 years and decreased slightly from 2021 when it was 53.2.

General fertility rate per 1,000 in Shropshire including regional neighbours, with West Midlands and England comparisons, 2022. Source: Child and Maternal Health Profile, Fingertips, OHID

Lower 95% | Similar | Higher 95% | Not compared

Recent trends: – Could not be calculated | No significant change | Increasing | Decreasing

General fertility rate 2022

Crude rate - per 1,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	577,046	51.9	51.8	52.0
West Midlands region (statistical)	↓	63,368	55.4	54.9	55.8
Walsall	↓	3,502	63.0	61.0	65.2
Wolverhampton	→	3,323	62.6	60.5	64.7
Sandwell	↓	4,330	61.7	59.9	63.6
Stoke-on-Trent	↓	3,059	60.4	58.3	62.6
Dudley	→	3,439	58.2	56.3	60.2
Birmingham	↓	14,482	55.5	54.6	56.4
Telford and Wrekin	↓	1,991	55.2	52.8	57.7
Staffordshire	↓	8,021	53.1	52.0	54.3
Herefordshire	→	1,521	52.9	50.3	55.6
Warwickshire	↓	5,757	52.5	51.1	53.9
Solihull	↓	1,983	52.4	50.1	54.7
Coventry	↓	4,059	51.7	50.1	53.3
Shropshire	→	2,567	51.6	49.6	53.6
Worcestershire	↓	5,334	51.5	50.2	52.9

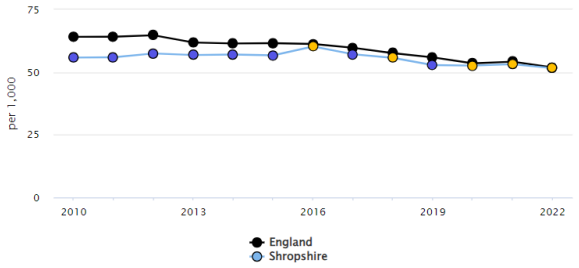
General fertility rate in Shropshire including nearest statistical neighbours, with England comparison, 2022. Source: Child and Maternal Health Profile, Fingertips, OHID

General fertility rate 2022

Crude rate - per 1,000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↓	-	577,046	51.9	51.8	52.0
Neighbours average	–	-	-	-	-	-
Wiltshire	↓	4	4,503	53.2	51.7	54.8
Herefordshire	→	2	1,521	52.9	50.3	55.6
Shropshire	→	-	2,567	51.6	49.6	53.6
Dorset	↓	3	2,615	49.0	47.2	50.9
Devon	↓	1	6,132	45.8	44.6	46.9
Somerset Cty	–	5	-	-	-	-

General fertility rate per 1,000 in Shropshire including regional neighbours, with West Midlands and England comparisons, 2010 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
2010		2,889	55.8	53.8	57.9	65.3	64.1
2011		2,879	55.9	53.9	58.0	66.1	64.2
2012		2,913	57.5	55.4	59.6	67.2	64.7
2013		2,844	56.8	54.8	59.0	64.8	61.8
2014		2,834	57.1	55.0	59.2	64.0	61.5
2015		2,795	56.7	54.6	58.9	63.7	61.6
2016		2,947	60.2	58.1	62.4	64.6	61.2
2017		2,793	57.1	55.0	59.3	62.9	59.7
2018		2,713	55.7	53.6	57.9	60.7	57.6
2019		2,587	52.8	50.8	54.9	59.1	55.9
2020		2,578	52.6	50.6	54.7	56.9	53.5
2021		2,639	53.2	51.2	55.2	56.5	54.2
2022		2,567	51.6	49.6	53.6	55.4	51.9

Source: OHID, based on Office for National Statistics data

Overall, fertility and birth rates have remained steady over the last two years in Shropshire with a small fall in general fertility rates to 51.4 births per 1,000 females in 2022 compared to the previous year and a small fall in total fertility rates to 1.53 births per 1,000 females. The average age of mothers in Shropshire currently stands at 30 years old.

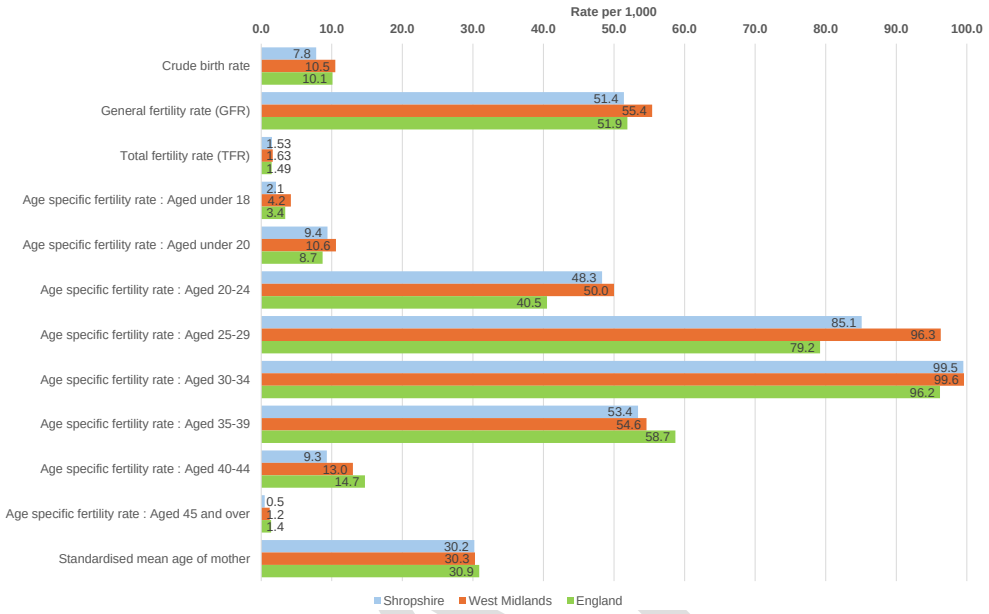
Live births, birth rates and mean age of mother in Shropshire, 2020-22. Source: Live births in England and Wales: birth rates down to local authority areas, NOMIS[17]

Shropshire	**2020**	**2021**	**2022**
Live births	2,578	2,639	2,567
Crude birth rate	8.0	8.1	7.8
General fertility rate (GFR)	52.6	53.2	51.4
Total fertility rate (TFR)	1.57	1.57	1.53
Age specific fertility rate : Aged under 18	3.0	1.2	2.1
Age specific fertility rate : Aged under 20	8.3	7.3	9.4
Age specific fertility rate : Aged 20-24	52.8	45.7	48.3
Age specific fertility rate : Aged 25-29	89.1	90.2	85.1
Age specific fertility rate : Aged 30-34	103.1	104.8	99.5
Age specific fertility rate : Aged 35-39	49.5	56.0	53.4
Age specific fertility rate : Aged 40-44	10.3	10.6	9.3
Age specific fertility rate : Aged 45 and over	0.6	0.2	0.5
Standardised mean age of mother	30.1	30.4	30.2

In 2022, Shropshire had a lower crude birth rate (7.8 births per 1,000 females), compared to the West Midlands region (10.5) and England (10.1) [18], and the general fertility rate (51.4 was also lower than both too. The 2,567 live births in Shropshire in 2022, accounted for just 4.1% of all the live births in the West Midlands region, and 0.4% of all live births in England. In Shropshire, fertility rates of mothers aged 30-34 are higher than regionally and nationally at 104.8 births per 1,000 females and this is rising over time.

[17] NOMIS Live births in England and Wales : birth rates down to local authority areas
[18] 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, 2022. Source: Live births in England and Wales: birth rates down to local authority areas, NOMIS[19]



The general fertility rate varies in different parts of Shropshire. The local health, public health data for small geographical areas [20], allows for the general fertility rate to be compared between wards in Shropshire for the five-year period 2016-20. In this five-year period Shropshire's fertility rate was 55.7 per 1,000 women, however, the Harlescott ward (80.6) had the highest rate in Shropshire with Shifnal South and Cosford (75.5), Battlefield (74.4), Highley (69.6), Castlefields and Ditherington (67.7), Shawbury (65.7) and Sundorne (65.7) all being significantly above Shropshire's rate. In contrast, eleven wards were significantly below Shropshire's rate, with the Porthill ward (31.4) having the lowest in Shropshire.

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

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

General fertility rate per 1,000 in Shropshire by electoral ward, 2016 to 2020. Source: Local health, public health data for small geographical areas, Fingertips, OHID

General fertility rate, live births per 1,000 women aged 15 to 44 years. Five year pooled 2016 - 20

Crude rate - per 1,000

Area	Count	Value	95% Lower CI	95% Upper CI
England	3,131,043	59.2	59.1	59.3
Shropshire	13,617	55.7	54.7	56.6
Harlescott	257	80.6	71.1	91.1
Shifnal South and Cosford	344	75.5	67.7	83.9
Battlefield	321	74.4	66.5	83.0
Highley	196	69.6	60.2	80.0
Castlefields and Ditherington	397	67.7	61.2	74.7
Shawbury	242	65.7	57.7	74.5
Sundorne	330	65.7	58.8	73.1
Ludlow East	201	64.8	56.1	74.4
Whittington	213	63.8	55.5	72.9
Bowbrook	297	63.3	56.3	70.9
St Martin's	211	62.5	54.4	71.6
Monkmoor	222	62.0	54.2	70.8
Bishop's Castle	162	62.0	52.9	72.4
Meole	225	61.8	54.0	70.4
Underdale	282	61.5	54.5	69.1
Hodnet	242	60.7	53.3	68.9
Copthorne	216	60.2	52.5	68.8
Market Drayton West	433	60.0	54.4	65.9
St Oswald	198	59.7	51.7	68.6
Shifnal North	259	59.5	52.5	67.2
Broseley	239	59.4	52.1	67.5
Oswestry East	542	59.4	54.5	64.6
Whitchurch North	336	58.6	52.5	65.2
Rea Valley	169	58.0	49.6	67.5
Prees	179	57.9	49.8	67.1
Severn Valley	207	57.9	50.3	66.4
Cheswardine	127	57.9	48.2	68.8
Corvedale	105	57.7	47.2	69.8
Whitchurch South	219	57.6	50.3	65.8
Bayston Hill, Column and Sutton	512	56.4	51.7	61.6
Church Stretton and Craven Arms	315	56.4	50.4	63.0
Cleobury Mortimer	255	56.1	49.4	63.4
Radbrook	156	55.5	47.1	64.9
Bagley	222	54.9	47.9	62.6
Market Drayton East	229	54.6	47.7	62.1
Clee	161	54.5	46.4	63.6
Gobowen, Selattyn and Weston Rhyn	342	54.1	48.5	60.1
Wem	383	52.6	47.5	58.1
Ellesmere Urban	180	52.5	45.1	60.8
Albrighton	181	52.4	45.1	60.6
Longden	208	52.0	45.2	59.5
Chirbury and Worthen	99	51.7	42.0	63.0
Bridgnorth West and Tasley	330	51.6	46.2	57.5
Ruyton and Baschurch	132	51.5	43.1	61.0
Worfield	100	50.7	41.2	61.6
Llanymynech	146	50.1	42.3	59.0
Bridgnorth East and Astley Abbotts	215	49.2	42.9	56.2
Oswestry West	130	48.7	40.7	57.8
Loton	125	48.4	40.3	57.7
Alveley and Claverley	137	48.3	40.6	57.1
Ludlow South	172	48.1	41.2	55.8
Ludlow North	91	47.8	38.5	58.7
Abbey	134	45.7	38.3	54.2
Much Wenlock	89	43.0	34.5	52.9
Belle Vue	171	42.6	36.5	49.5
Oswestry South	151	42.5	36.0	49.9
Tern	105	42.0	34.4	50.9
Brown Clee	101	41.9	34.1	50.9
The Meres	149	40.6	34.4	47.7
Clun	80	37.9	30.1	47.2
Quarry and Coton Hill	166	37.8	32.2	44.0
Burnell	168	33.8	28.9	39.3
Porthill	111	31.4	25.8	37.8

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[21]. 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 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 [22]:

- 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 2021, there were 65 pregnancies among girls and women aged under 18, equating to rate of 12.5 per 1,000 population, similar to the national rate of 13.1 and below the regional rate. This ranks Shropshire third lowest in the West Midlands[23]. Shropshire's rate is similar to most of its nearest statistical neighbours, with four local authorities having lower rates, but only Wiltshire significantly lower. Shropshire's conception rates have gone up in each of the last four years, although are still nearly half the rate they were ten years ago.

[21] Public health profiles - OHID (phe.org.uk)
[22] Teenage pregnancy prevention framework 2018
[23] Child and Maternal Health - Data - OHID (phe.org.uk)

Under 18s conception rate per 1,000 in Shropshire including regional neighbours, with West Midlands and England comparisons, 2021. Source: Child and Maternal Health Profile, Fingertips, OHID

Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

Under 18s conception rate / 1,000 2021

Crude rate - per 1,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	12,361	13.1	12.9	13.3
West Midlands region	–	1,587	15.2	14.5	16.0
Stoke-on-Trent	–	107	24.4	20.0	29.5
Telford and Wrekin	–	65	19.5	15.0	24.8
Walsall	–	101	18.9	15.4	23.0
Coventry	–	109	18.6	15.2	22.4
Wolverhampton	–	87	18.5	14.8	22.8
Dudley	–	95	17.3	14.0	21.1
Staffordshire	–	224	16.2	14.1	18.5
Herefordshire	–	41	14.7	10.6	20.0
Sandwell	–	93	14.1	11.4	17.2
Birmingham	–	316	13.5	12.0	15.0
Warwickshire	–	125	13.0	10.8	15.5
Shropshire	–	65	12.5	9.7	16.0
Worcestershire	–	116	11.7	9.6	14.0
Solihull	–	43	11.4	8.2	15.3

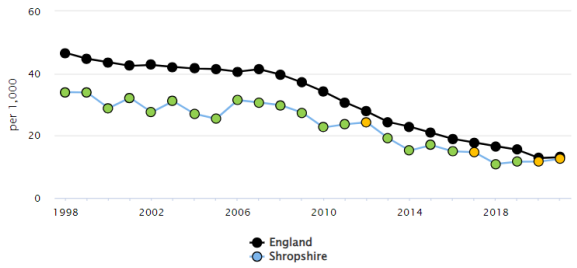
Under 18s conception rate in Shropshire including nearest statistical neighbours, with England comparison, 2021. Source: Child and Maternal Health Profile, Fingertips, OHID

Under 18s conception rate / 1,000 2021

Crude rate - per 1,000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↓	-	12,361	13.1	12.8	13.3
Neighbours average	–	-	-	-	-	-
Herefordshire	→	2	41	14.7	10.6	20.0
Shropshire	→	-	65	12.5	9.7	16.0
Somerset Cty	→	5	111	11.9	9.8	14.3
Devon	→	1	122	10.0	8.3	11.9
Dorset	→	3	48	8.0	5.9	10.7
Wiltshire	→	4	61	7.0	5.4	9.0

Under 18s conception rate per 1,000 in Shropshire including regional neighbours, with West Midlands and England comparisons, 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	England
1998		177	34.0	29.2	39.4	46.6
1999		171	33.9	29.0	39.4	44.8
2000		144	28.9	24.3	34.0	43.6
2001		165	32.2	27.5	37.5	42.5
2002		143	27.5	23.2	32.4	42.8
2003		165	31.1	26.5	36.2	42.1
2004		148	27.0	22.8	31.7	41.6
2005		144	25.4	21.5	30.0	41.4
2006		185	31.4	27.1	36.3	40.6
2007		183	30.7	26.4	35.5	41.4
2008		176	29.8	25.6	34.6	39.7
2009		160	27.4	23.3	32.0	37.1
2010		131	22.7	18.9	26.9	34.2
2011		136	23.7	19.8	28.0	30.7
2012		137	24.3	20.4	28.7	27.8
2013		107	19.2	15.7	23.2	24.4
2014		85	15.2	12.1	18.8	22.9
2015		93	17.0	13.7	20.8	20.9
2016		81	15.0	11.9	18.6	19.0
2017		79	14.7	11.6	18.3	17.8
2018		58	10.9	8.3	14.1	16.6
2019		62	11.6	8.9	14.9	15.5
2020		62	11.7	8.9	15.0	12.8
2021		65	12.5	9.7	16.0	13.1

In 2021, there were 14 pregnancies among under 16 year olds in Shropshire, equating to a rate of 2.7 per 1,000 under 16-year-olds, up from 1.4 per 1,000 the previous year. This ranks Shropshire sixth lowest in the West Midlands region, which in total has a rate of 2.4 per 1,000 and is similar to the national rate of 2.1 per 1,000. Compared to its statistical neighbours, Shropshire ranks as the highest, it is statistically similar to all other neighbours.

In Shropshire, the rate of Under 16 pregnancy's has been generally decreasing over time and remains similar to the national average at 2.1 per 1,000, however, there was a bit of an increase in the most recent year.

Under 16s conception rate per 1,000 in Shropshire including regional neighbours, with West Midlands and England comparisons, 2021. Source: Child and Maternal Health Profile, Fingertips, OHID

Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

C02b - Under 16s conception rate / 1,000 **New data** 2021

Crude rate - per 1,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	2,053	2.1	2.0	2.2
West Midlands region (statistical)	↓	259	2.4	2.1	2.7
Stoke-on-Trent	→	29	6.1	4.1	8.8
Walsall	→	21	3.8	2.3	5.8
Dudley	→	20	3.6	2.2	5.6
Telford and Wrekin	→	11	3.2	1.6	5.7
Coventry	→	17	2.8	1.6	4.4
Shropshire	→	14	2.7	1.5	4.6
Wolverhampton	→	14	2.7	1.5	4.5
Staffordshire	→	35	2.4	1.7	3.4
Worcestershire	→	19	1.9	1.1	2.9
Solihull	→	7	1.8	0.7	3.8
Sandwell	→	12	1.7	0.9	3.0
Birmingham	→	41	1.7	1.2	2.3
Warwickshire	→	17	1.7	1.0	2.7
Herefordshire	→	2	0.7	0.1	2.6

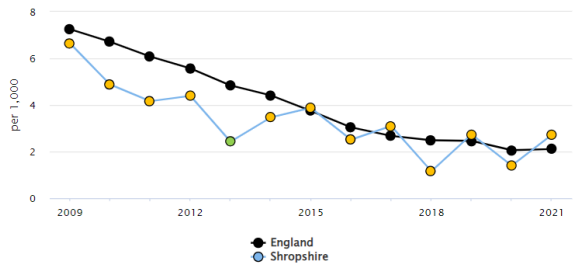
Under 16s conception rate per 1,000 in Shropshire including nearest statistical neighbours, with England comparisons, 2021. Source: Child and Maternal Health Profile, Fingertips, OHID

Under 16s conception rate / 1,000 2021

Crude rate - per 1,000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↓	-	2,053	2.1	2.0	2.2
Neighbours average	–	-	-	-	-	-
Shropshire	→	-	14	2.7	1.5	4.6
Devon	→	1	27	2.1	1.4	3.1
Somerset Cty	→	5	17	1.8	1.0	2.9
Wiltshire	→	4	9	1.0	0.5	1.9
Herefordshire	→	2	2	0.7	0.1	2.6
Dorset	→	3	4	0.7	0.2	1.7

Under 16s conception rate per 1,000 in Shropshire, with England comparison, 2009 to 2021. Source: Child and Maternal Health Profile, Fingertips, OHID



Recent trend: No significant change

Period		Shropshire Count	Value	95% Lower CI	95% Upper CI	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

Source: OHID, based on Office for National Statistics data

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.

There are two indicators on the child and maternal health profile [24] for early access to maternity care, the first is from 2018-19, several years ago, in which Shropshire's figure was 51.2% which was significantly worse than England (57.8%), however, the method of extracting the data has now been adjusted and the new indicator shows data for 2023-24, although this indicator is in development. Under this new method, the early access to maternity care was 58.6% in Shropshire, significantly below England (63.5%) and West Midlands region (61.2%). When compared to Shropshire's five nearest statistical neighbours, four other local authorities have a higher percentage, three of which significantly higher. There is no trend data available on the OHID profile.

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

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

Early access to maternity care **New data** 2023/24 — Proportion - %

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, with England comparison, 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID

Early access to maternity care **New data** 2023/24 — Proportion - %

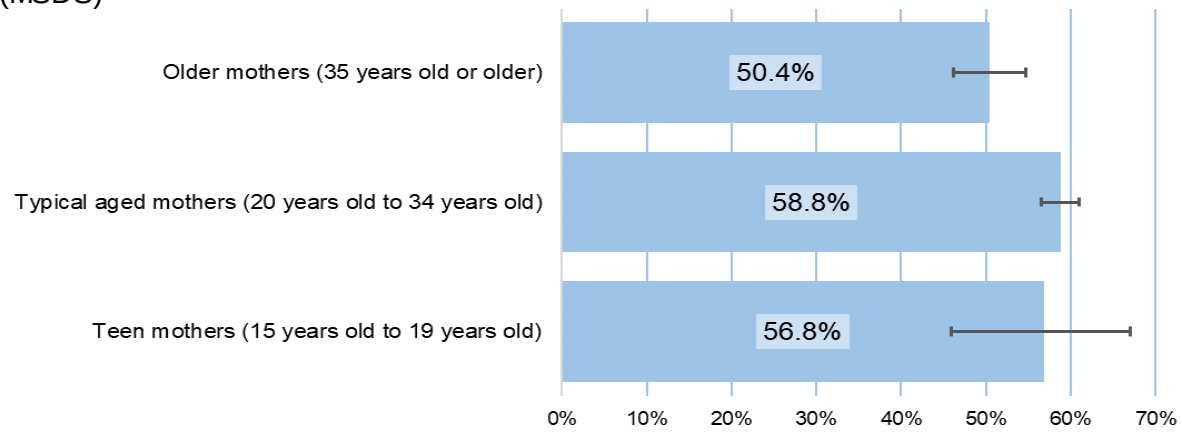
Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	→	-	397,575	63.5	63.4	63.7
Neighbours average	–	-	-	-	-	-
Wiltshire	→	4	3,950	82.0	81.0	83.1
Devon	→	1	5,105	76.3	75.2	77.3
Dorset	↑	3	2,035	73.5	71.8	75.1
Herefordshire	↓	2	1,035	62.5	60.1	64.7
Shropshire	→	-	1,515	58.6	56.6	60.4
Somerset Cty	–	5	-	-	-	-

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.

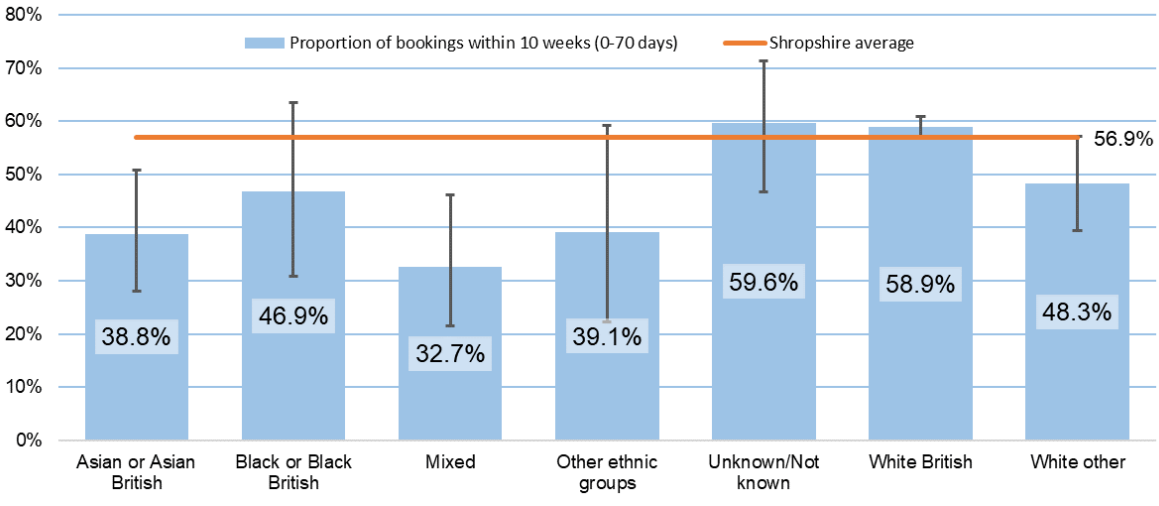
Local analysis using data extracted from the national Maternity Services Data Set (MSDS), covering the same period, April 2023 to March 2024, identified 2,464 bookings recorded to persons living within the Shropshire area, of whom just 56.9% recorded their first antenatal booking appointment within 10 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 time of booking, 2023-24. Source Maternity Services Data Set (MSDS)



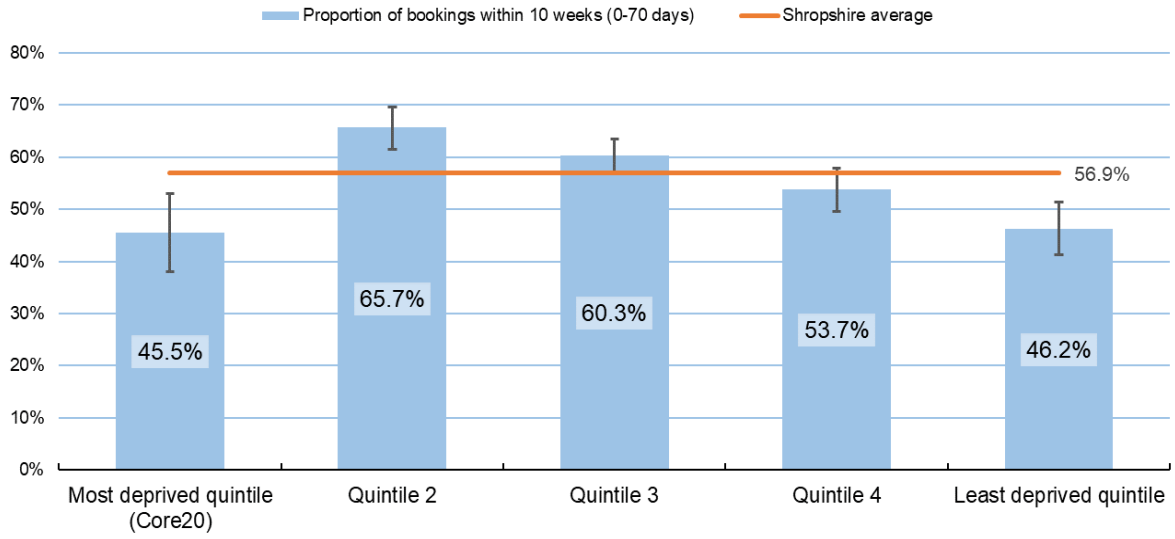
Analysis by ethnicity found that whilst mothers with a White British ethnicity were more likely to be seen in the 10-week target (59%, 1,245) they had a statistically similar rate as mothers from the *White other* (48.3%, 57), *Black or Black British* (46.9%, 15), and *other* ((39.1%, 9) ethnic groupings 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.

There are two indicators on the child and maternal health profile [25] for folic acid supplements taken before pregnancy, the first is from 2018-19, several years ago, in which Shropshire's figure was 31.6% which was significantly above the national figure (27.3%), however, the method of extracting the data has now been adjusted and the new indicator shows data for 2023-24, although there do seem to be concerns about the quality of the data of this indicator due to the data collection methods.

In this period, 1.5% of women in Shropshire were taking folic acid supplements before pregnancy, which is significantly worse than the England figure of 19.7% and the West Midlands average of 8%. Shropshire ranked third lowest in the West Midlands region, behind only Dudley (1%) and Telford and Wrekin (0.5%), and Shropshire's rate was the lowest among its statistical neighbours. The trend data shows that Shropshire's rate has dropped

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

dramatically 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%). The OHID profile reports some caveats which might explain this – "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 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." [26]

Percentage taking folic acid supplements before pregnancy in Shropshire including regional neighbours, with West Midlands and England comparisons, 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	–	-	*	-	-

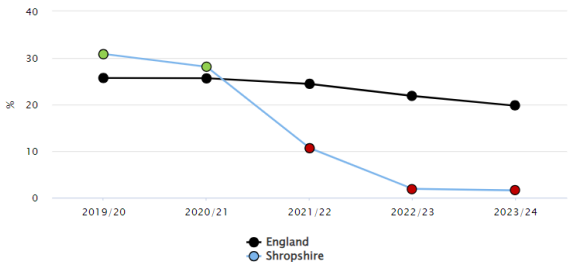
Percentage taking folic acid supplements before pregnancy in Shropshire including nearest statistical neighbours, with England comparison, 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID

Folic acid supplements taken before pregnancy ⚠ New data 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	–	-	-	-	-	-
Wiltshire	→	4	1,405	29.2	27.9	30.5
Dorset	↓	3	395	14.3	13.0	15.6
Devon	↓	1	620	9.8	9.1	10.6
Herefordshire	↓	2	100	6.1	5.0	7.3
Shropshire	↓	-	40	1.5	1.1	2.1
Somerset Cty	–	5	-	-	-	-

[26] 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. This 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 two indicators on the child and maternal health profile [27] for smoking in early pregnancy, the first is from 2018-19, several years ago, in which Shropshire’s figure was 14.2% which was significantly above the national figure (12.8%), however, the method of extracting the data has now been adjusted and the new indicator shows data for 2023-24, although there is a caveat that there are concerns about the quality of the data for this indicator due to the data collection methods.

In this period, 18.4% of women in Shropshire were known to be smokers at this time, which is significantly worse than the England figure of 13.6% and the West Midlands average of 13%. Shropshire ranked second highest in the West Midlands region, behind only Telford and Wrekin (21.2%), with both significantly above the other areas, and Shropshire’s rate was the highest among its statistical neighbours. The trend data shows that 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%).

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

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

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

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, with England comparison, 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID

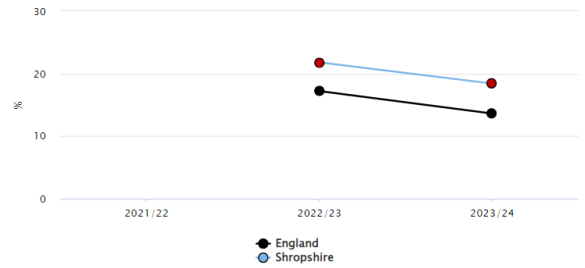
Smoking in early pregnancy ⚠ New data 2023/24 — Proportion - %

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	60,725	13.6	13.5	13.7
Neighbours average	–	-	-	-	-	-
Shropshire	–	-	420	18.4	16.9	20.1
Dorset	–	3	380	14.8	13.5	16.2
Wiltshire	–	4	540	13.3	12.3	14.3
Herefordshire	–	2	165	11.2	9.6	12.9
Devon	–	1	-	*	-	-
Somerset Cty	–	5	-	-	-	-

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

Smoking in early pregnancy ⚠ New data — Proportion - %

Show confidence intervals Show 99.8% CI values ▶ More options



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

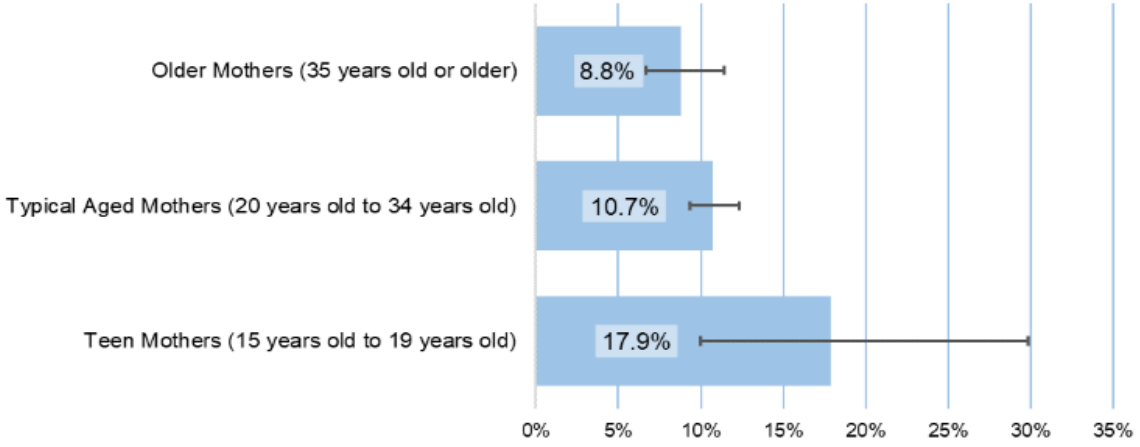
Indicator Definitions and Supporting Information

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.

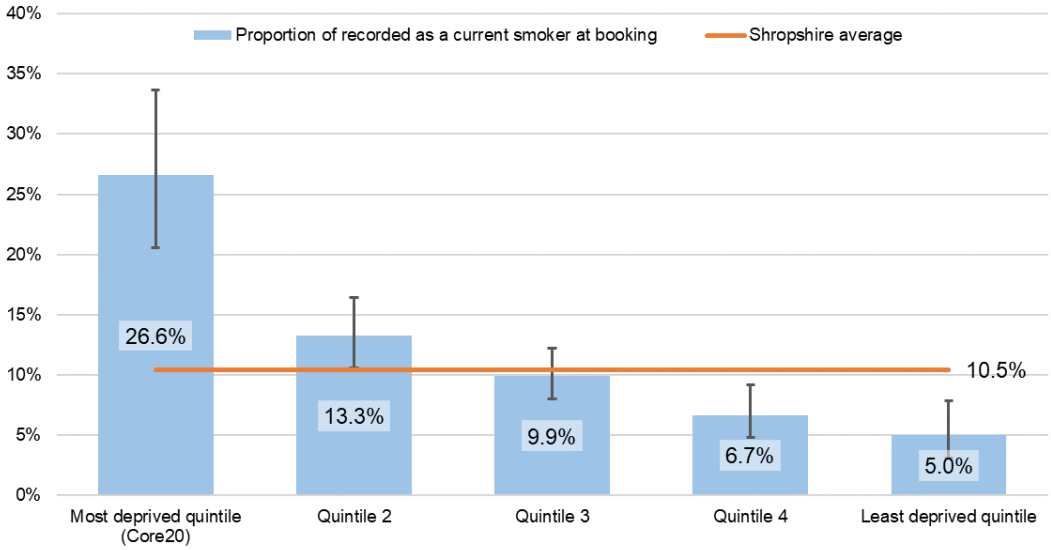
Social-demographic analysis found that smoking at time of booking appears to be connected to the white ethnicity, with 11% (225) of White British and 12% (14) of White other mothers identified as smokers at the beginning of their pregnancy compared to just 2% (4) of mothers from all other ethnicities. Whilst 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.



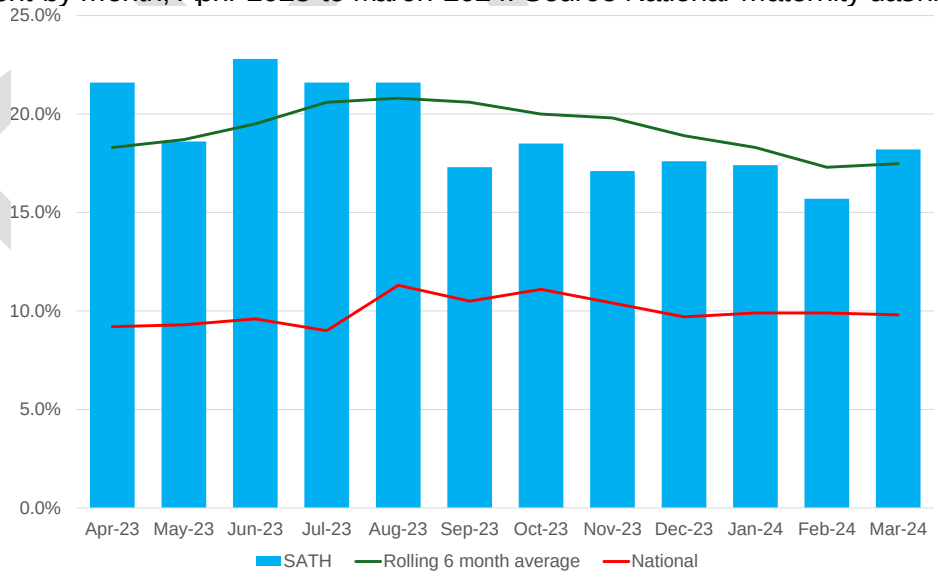
Deprivation continues to be a key driver of tobacco use with 27% (46) of mothers from the most deprived neighbourhoods (IMD2019) recorded as being a smoker at the time of booking, compared to just 5% (17) of mothers from the least deprived neighbourhoods.

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, compared to nationally in the last year. The 6-month rolling average shows a peak of 20.8% in August 2023, compared to a national figure of 11.3%, although rates have been dropping with the most recent 6 monthly figure in March 2024 being 17.5%, which is still higher than 9.8% nationally [28].

Percentage of mothers recorded as being a current smoker at their first antenatal appointment by month, April 2023 to March 2024. Source National maternity dashboard



[28] National Maternity dashboard

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.

There are two indicators on the child and maternal health profile [29] for obesity in early pregnancy, the first is from 2018-19, several years ago, in which Shropshire's figure was 24.1% which was significantly above the national figure (22.1%), however, the method of extracting the data has now been adjusted and the new indicator shows data for 2023-24, although there are concerns about the quality of the data of this indicator due to the data collection methods. As this new definition is still in development, no data was published for several local authorities including Shropshire for this period, however the national figure was 26.2%, and the West Midlands regional figure was significantly higher at 28.7%. Only three of Shropshire's statistical neighbours had figures published, two of which were significantly above England's. The is no trend data available on the OHID profile.

Percentage of women obese at booking appointment in Shropshire including regional neighbours, with West Midlands and England comparisons, 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
Birmingham	–	-	*	-	-
Coventry	–	-	*	-	-
Sandwell	–	-	*	-	-
Shropshire	–	-	*	-	-
Staffordshire	–	-	*	-	-
Stoke-on-Trent	–	-	*	-	-
Telford and Wrekin	–	-	*	-	-
Walsall	–	-	*	-	-
Warwickshire	–	-	*	-	-

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

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

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

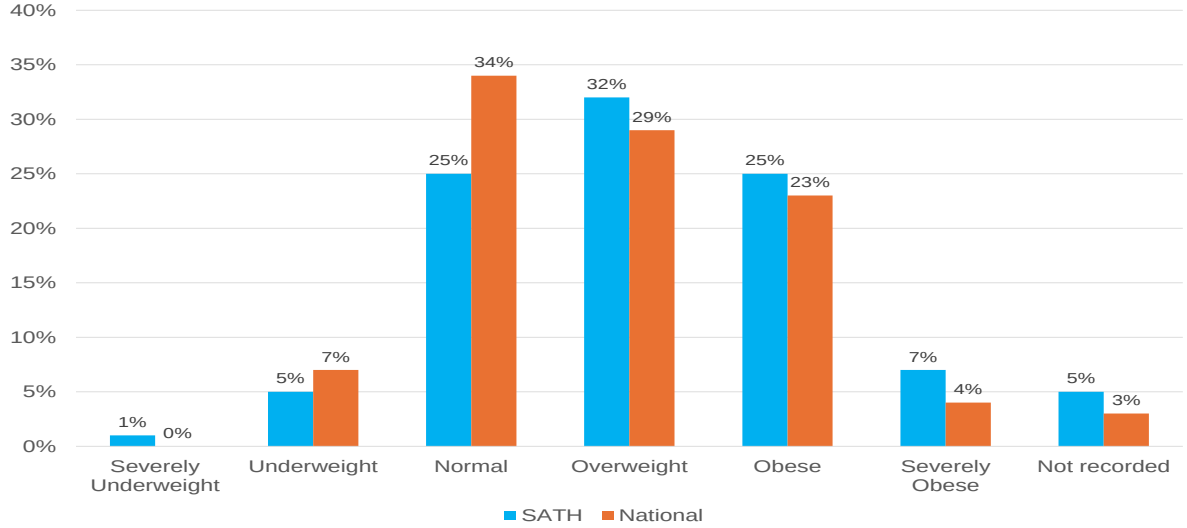
Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	100,525	26.2	26.1	26.3
Neighbours average	–	-	-	-	-	-
Wiltshire	–	4	1,135	28.6	27.2	30.1
Dorset	–	3	685	28.6	26.7	30.3
Herefordshire	–	2	345	25.7	23.3	27.9
Shropshire	–	-	-	*	-	-
Devon	–	1	-	*	-	-
Somerset Cty	–	5	-	-	-	-

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 and can be replicated using local MSDS data with the latest figures covering the May 2024 period, showing that of those mothers whose gestation period was at or below 15 weeks 6% were servery obese, 31% obese, 26% overweight and 4% were underweight with just 33% recorded as having a BMI within the Normal (healthy weight) range.

The national maternity dashboard shows that when mothers BMI was measured at 15 weeks gestation in the last year, a lower percentage of mothers at The Shrewsbury and Telford Hospital NHS Trust were considered a 'normal' BMI (25%) compared to nationally (34%), meanwhile more mothers were 'overweight' – 32% compared to 29%, more mothers were 'obese' or 'severely obese' compared to nationally – 25% and 7%, compared to 23% and 4% respectively[30].

BMI of mother at 15 weeks gestation, Shrewsbury and Telford Hospital compared to the national average, April 2023 – March 2024. Source National maternity dashboard, NHS England



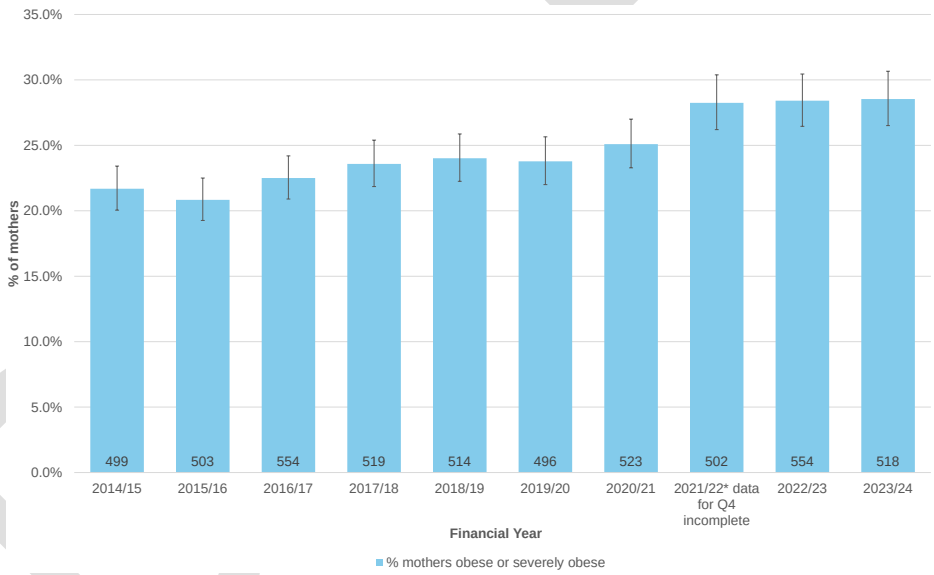
[30] National Maternity dashboard

Local data obtained from SATH about births that occurred there when the mother was registered at Shropshire medical practices, included retrospective data about their booking appointment which allowed for deeper analysis, including the mother's BMI at their booking appointment. There has been a steady rise in obesity levels from 21.7% in 2014-15 to 28.5% in 2023-24 with rates in 2023-24 significantly higher than they were before 2020-21. This means that although there are less deliveries in 2023-24 than 2018-19, there were nearly the same number of mothers who were obese or severely obese at their booking appointment.

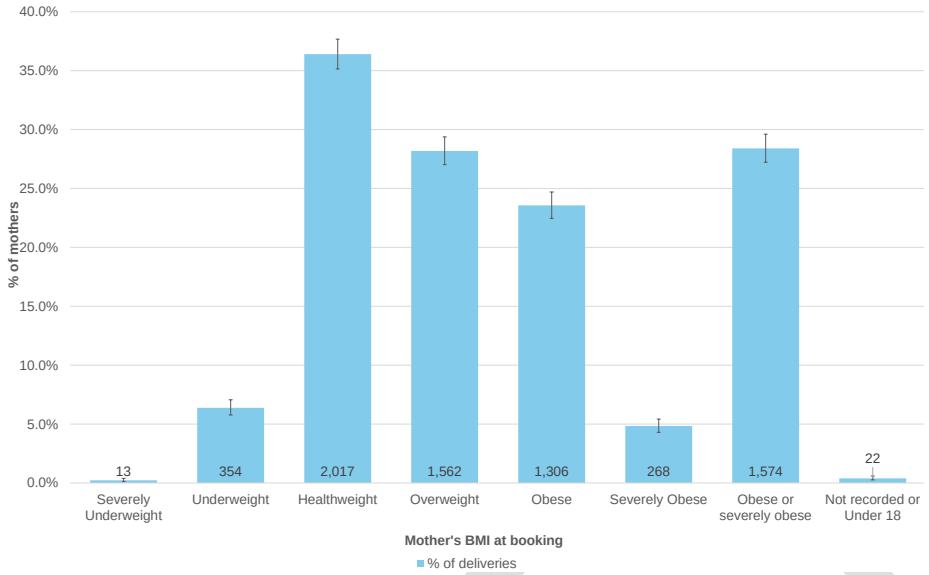
The analysis also looked at the three-year period 2021-22 to 2023-24 to look at the range of mother's BMI recorded – 36% of mothers were a healthyweight, 28% were overweight and 24% of mothers were obese, with a further 5% severely obese (BMI 40 or over) – in this period, 1,574 mothers were either obese or severely obese.

When overall obesity was just 11% in the under 20 age group but rose to 30% among 20–24-year-olds and to 30.3% in the 25-29 age group. However, obesity was lower in mothers aged 30-34 (28.2%) and 35-39 (25.6%), while the mothers aged 40 or older had the highest rate at 37%. There are higher obesity levels in the more deprived quintile in Shropshire (30%), which was significantly higher than the two least deprived quintiles.

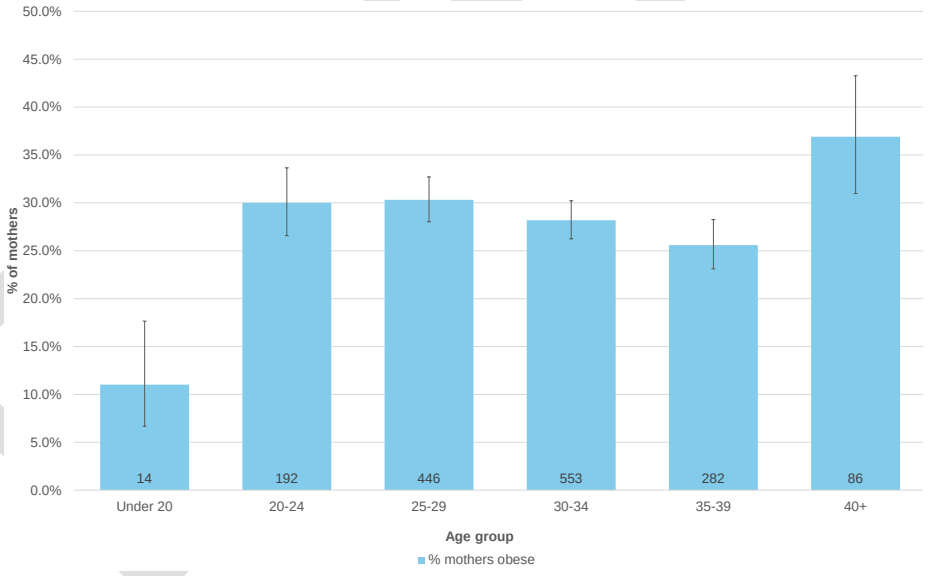
Obesity trends at booking appointment for Shropshire mothers who delivered at SATH, 2014-15 to 2023-24. Source: Maternity Database, Shrewsbury and Telford Hospital NHS Trust



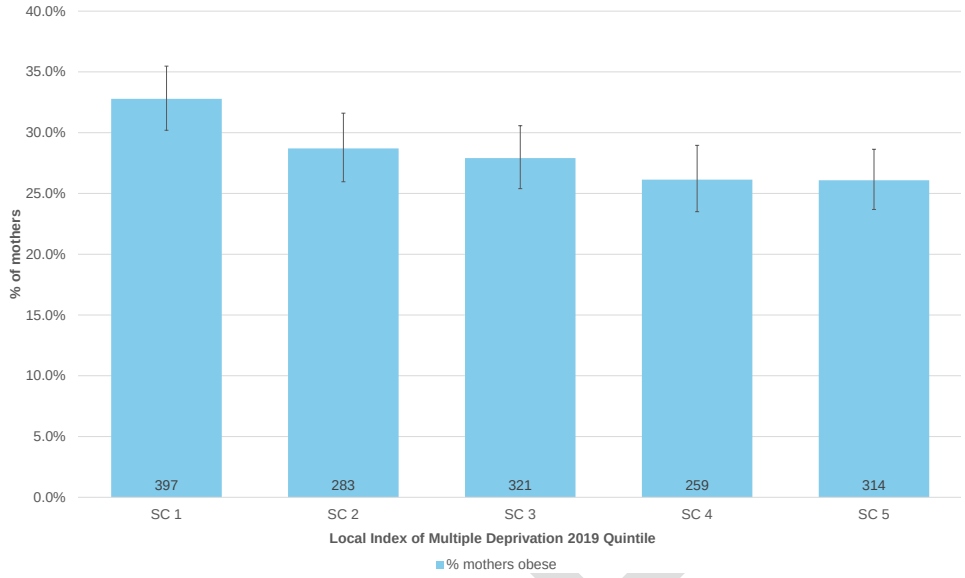
BMI at booking appointment for Shropshire mothers who delivered at SATH, 2021-22 to 2023-24. Source: Maternity Database, Shrewsbury and Telford Hospital NHS Trust



Obesity at booking appointment for Shropshire mothers who delivered at SATH by age group, 2021-22 to 2023-24. Source: Maternity Database, Shrewsbury and Telford Hospital NHS Trust



Obesity at booking appointment for Shropshire mothers who delivered at SATH by Shropshire IMD2019 quintile, 2021-22 to 2023-24. Source: Maternity Database, Shrewsbury and Telford Hospital NHS Trust



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 2023-24, 9.9% of women in Shropshire were known to be smokers at the time of delivery, a proportion significantly worse than the West Midlands average of 7.8% and England average of 7.4%. Shropshire currently ranks third highest in the West Midlands region and highest among its statistical neighbours[31]. The trends show that Shropshire has been consistently above the England rate going back to 2010-11 although it has dropped from 12% in 2021-22.

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

Percentage of women known to be smokers at the time of delivery in Shropshire with West Midlands and England comparisons, 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID

Smoking status at time of delivery 2023/24

Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	38,884	7.4	7.4	7.5
West Midlands region (statistical)	↓	4,736	7.8	7.6	8.0
Stoke-on-Trent	↓	306	10.3	9.3	11.4
Telford and Wrekin	↓	180	9.9	8.6	11.4
Shropshire	→	231	9.9	8.7	11.2
Wolverhampton	↓	285	8.9	7.9	9.9
Walsall	↓	301	8.9	8.0	9.9
Sandwell	→	373	8.9	8.0	9.8
Dudley	→	295	8.9	7.9	9.9
Worcestershire	↓	413	8.3	7.5	9.1
Herefordshire	↓	117	8.3	6.9	9.8
Staffordshire	↓	567	7.7	7.1	8.4
Warwickshire	↓	371	7.3	6.7	8.1
Coventry	↓	263	7.3	6.5	8.3
Solihull	↓	124	6.0	5.1	7.1
Birmingham	↓	910	6.0	5.7	6.4

Percentage of women known to be smokers at the time of delivery in Shropshire with nearest statistical neighbours and England comparisons, 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID

Smoking status at time of delivery 2023/24

Proportion - %

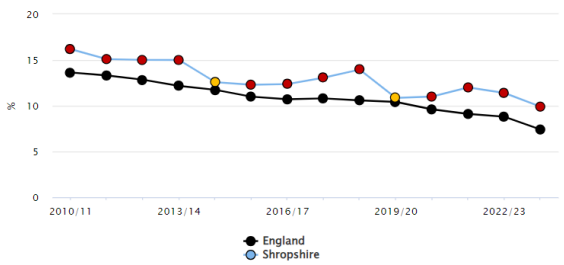
Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↓	-	38,884	7.4	7.4	7.5
Neighbours average	–	-	-	-	-	-
Shropshire	→	-	231	9.9	8.7	11.2
Somerset Cty	↓	5	409	9.1	8.3	10.0
Herefordshire	↓	2	117	8.3	6.9	9.8
Devon	↓	1	439	8.0*	7.3	8.7
Dorset	↓	3	150	7.7*	6.6	8.9
Wiltshire	↓	4	271	6.6	5.9	7.4

Percentage of women known to be smokers at the time of delivery in Shropshire with England comparisons, 2010-11 to 2023-24. Source: Child and Maternal Health Profile, Fingertips, OHID

Smoking status at time of delivery

Proportion - %

Show confidence intervals Show 99.8% CI values ▶ More options



Recent trend: → No significant change

Period		Shropshire Count	Value	95% Lower CI	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%

Source: OHID, based on NHS England data

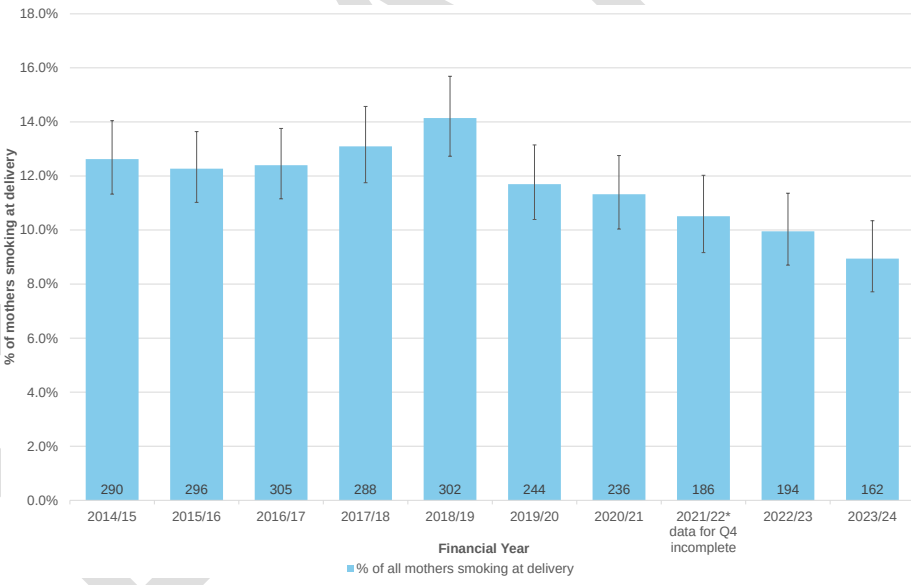
Local data

Local data obtained from SATH about births that occurred there when the mother was registered at Shropshire medical practices, included retrospective data about their booking appointment which allowed for deeper analysis.

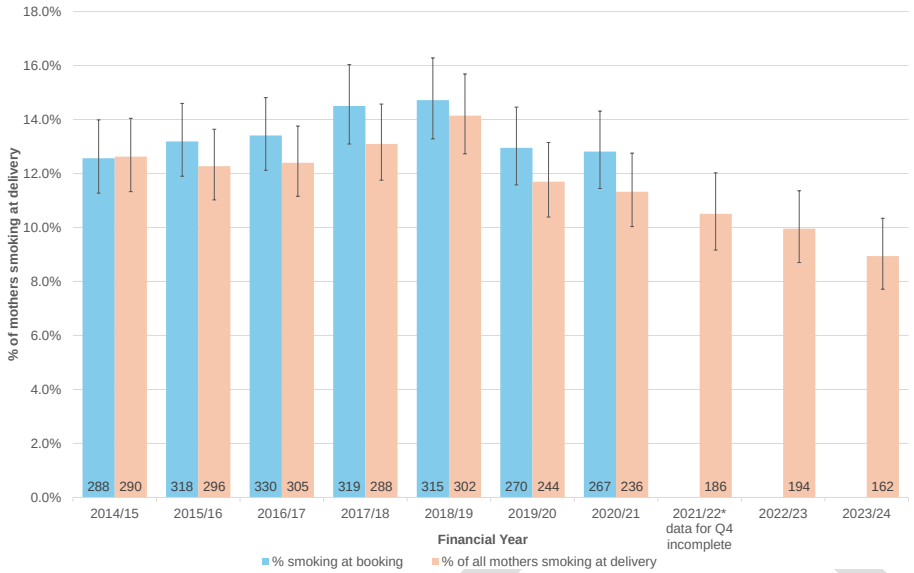
There had been a steady rise in smoking at delivery levels from 2014-15 to a high of 14.1% in 2018-19, but in the years since the rates have come down, with the most recent period of 2023-24 showing a rate of 8.9% - in this period the number of smokers at time of delivery has fallen from 302 to 162. In the last year where smoking at booking data was available, 2020-21 (as it is the same cohort of mothers), this shows the drop in the numbers smoking between those periods – in this year the percentage of smokers at booking was 12.8% (267 women) and the percentage of smokers at delivery was 11.3% (236 women).

In the three-year period 2021-22 to 2023-24, there were a total of 542 smokers at the time of delivery. The smoking rates were significantly highest in the mothers aged under 20 (18.9%, 24 smokers) and the 20-24 age group (19.1%, 122 smokers), while rates in those aged 30 or over were just 6.2%. There are also significantly higher smoking rates in the most deprived Shropshire quintiles (19%), compared to all other quintiles, with the smoking rates in the least deprived quintile being under 5%.

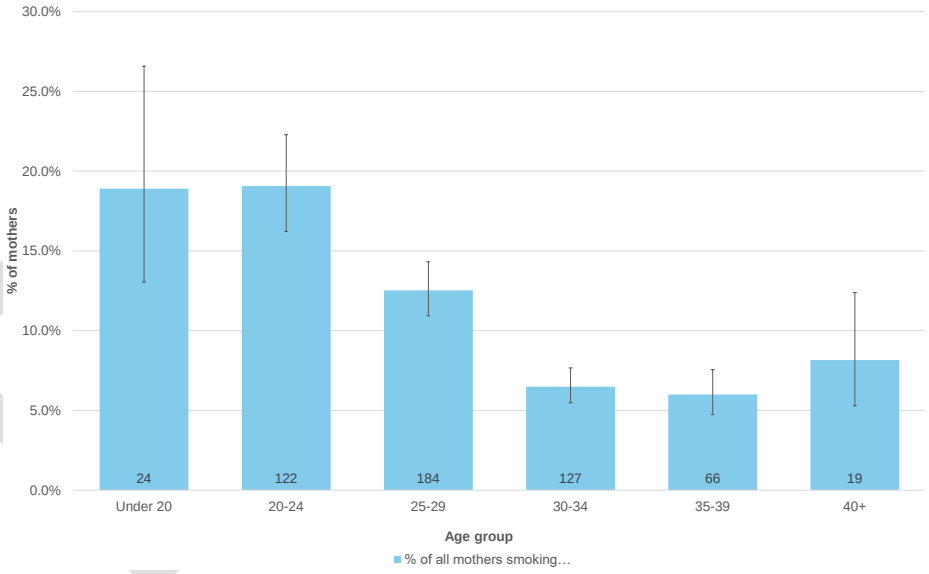
Smoking at the time of delivery for Shropshire mothers who delivered at SATH, 2014-15 to 2023-24. Source: Maternity Database, Shrewsbury and Telford Hospital NHS Trust



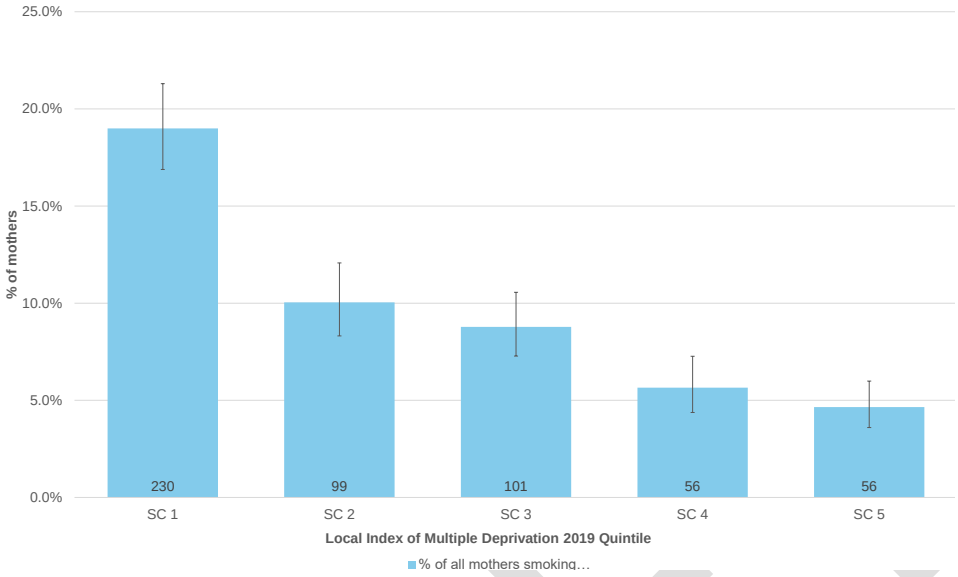
Smoking at the time of delivery for Shropshire mothers who delivered at SATH, 2014-15 to 2023-24. Source: Maternity Database, Shrewsbury and Telford Hospital NHS Trust



Smoking at the time of delivery for Shropshire mothers who delivered at SATH by age group, 2021-22 to 2023-24. Source: Maternity Database, Shrewsbury and Telford Hospital NHS Trust



Smoking at the time of delivery for Shropshire mothers who delivered at SATH by Shropshire IMD2019 quintile, 2021-22 to 2023-24. Source: Maternity Database, Shrewsbury and Telford Hospital NHS Trust



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.

According to the profile in 2022-23, Shropshire had a caesarean section figure 36.4%, which would make it similar to England (37.8%) and the West Midlands (37.6%), which would be the tenth highest figure in the region and in the middle among nearest statistical neighbours, however, there appears to be a data quality issue with this figure for this year, with OHID stating that HES maternity data was not fully completed. 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 2021-22 being 29.4% (640 sections), compared to 34.7% in the West Midlands and 37.8 for England.

Percentage of caesarean sections in Shropshire including regional neighbours, with West Midlands and England comparisons, 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID

Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated | → No significant change | ↑ Increasing & getting worse | ↑ Increasing & getting better | ↓ Decreasing & getting worse | ↓ Decreasing & getting better

Caesarean section % 2022/23

Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↑	195,290	37.8	37.7	38.0
West Midlands region (statistical)	↑	20,580	37.6	37.2	38.0
Telford and Wrekin	↑	30	60.0*	42.3	68.8
Herefordshire	↑	620	42.5	40.0	45.0
Solihull	↑	760	41.4	39.2	43.7
Warwickshire	↑	2,105	39.5	38.3	40.9
Wolverhampton	↑	1,180	38.5	36.8	40.2
Staffordshire	↑	2,880	38.1	37.0	39.2
Birmingham	↑	5,245	37.7	36.9	38.6
Walsall	↑	925	37.2	35.3	39.1
Dudley	↑	1,190	37.0	35.3	38.7
Shropshire	↑	100	36.4*	31.0	42.3
Coventry	↑	1,390	36.3	34.8	37.9
Stoke-on-Trent	↑	1,060	36.2	34.4	37.9
Sandwell	↑	1,420	35.4	33.9	36.9
Worcestershire	↑	1,675	34.9	33.5	36.2

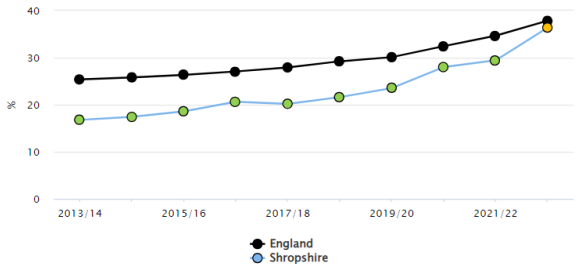
Percentage of caesarean sections in Shropshire including nearest statistical neighbours, with England comparison, 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID

Caesarean section % 2022/23

Proportion - %

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↑	-	195,290	37.8	37.7	38.0
Neighbours average	–	-	-	-	-	-
Herefordshire	↑	2	620	42.5	40.0	45.0
Dorset	↑	3	885	37.5	35.5	39.4
Shropshire	↑	-	100	36.4*	31.0	42.3
Wiltshire	↑	4	1,435	33.9	32.5	35.4
Devon	↑	1	2,100	31.3	30.2	32.4
Somerset Cty	↑	5	-	-	-	-

Percentage of caesarean sections in Shropshire, with West Midlands and England comparisons, 2013-14 to 2022-23. 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%

Source: NHS England

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. According to the profile in 2022, Shropshire had a under 18s birth rate per 1,000 of 2.2 (11 births), which makes it statistically similar to England (3.4), but significantly below the West Midlands (4.2) and is the second lowest in the region and the fifth lowest figure among nearest statistical neighbours. The trends data shows that the figure for Shropshire have always been below England's back to 2009, mostly significantly below, but because of the small numbers a small increase puts Shropshire's rate to become statistically similar.

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

Under 18s births rate / 1,000 2022 — Crude rate - per 1,000

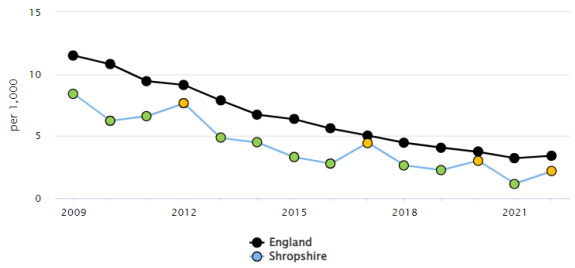
Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	3,279	3.4	3.3	3.5
West Midlands region (statistical)	↓	445	4.2	3.8	4.6
Stoke-on-Trent	→	36	7.9	5.5	10.9
Wolverhampton	→	34	6.8	4.7	9.5
Walsall	→	31	5.7	3.9	8.1
Coventry	→	30	5.0	3.4	7.1
Birmingham	→	110	4.7	3.8	5.6
Herefordshire	→	12	4.4	2.2	7.6
Staffordshire	→	60	4.2	3.2	5.5
Dudley	→	23	4.1	2.6	6.2
Telford and Wrekin	→	12	3.5	1.8	6.0
Sandwell	↓	22	3.2	2.0	4.9
Warwickshire	→	30	3.0	2.0	4.3
Worcestershire	→	27	2.6	1.7	3.8
Shropshire	→	11	2.2	1.1	3.9
Solihull	→	7	1.8	0.7	3.7

Under 18s birth rate per 1,000 in Shropshire including nearest statistical neighbours, with England comparison, 2022. Source: Child and Maternal Health Profile, Fingertips, OHID

Under 18s births rate / 1,000 2022 — Crude rate - per 1,000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↓	-	3,279	3.4	3.3	3.5
Neighbours average	–	-	322	2.8*	2.5	3.1
Herefordshire	→	3	12	4.4	2.2	7.6
Northumberland	→	10	21	4.3	2.7	6.6
Cumberland	→	7	18	4.3	2.5	6.8
Suffolk	→	8	44	3.6	2.6	4.8
Cornwall	→	11	31	3.5*	2.4	4.9
Cheshire East	→	15	22	3.3	2.1	5.1
North Yorkshire UA	→	1	30	3.0	2.0	4.3
Devon	→	14	36	2.9	2.0	4.0
East Riding of Yorkshire	→	6	13	2.4	1.3	4.1
Gloucestershire	→	9	25	2.3	1.5	3.4
Somerset UA	→	4	22	2.3	1.4	3.5
Shropshire	→	-	11	2.2	1.1	3.9
Westmorland and Furness	→	5	7	2.0	0.8	4.1
Dorset	→	12	11	1.8	0.9	3.3
Wiltshire	→	2	16	1.8	1.0	3.0
West Berkshire	→	13	3	1.0	0.2	2.8

Under 18s birth rate per 1,000 in Shropshire, with West Midlands and England comparisons, 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	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	2.2	1.1	3.9	3.4

Source: OHID, based on Office for National Statistics data

Multiple births 2022 Crude rate per 1,000

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 13.4 per 1,000, which was statistically similar to England (14.6) and the West Midlands (13.1) and is the sixth highest in the region and was the second 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, despite the rate sometimes being just below or above England's.

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

Multiple births **New data** 2022 — Crude rate - per 1,000

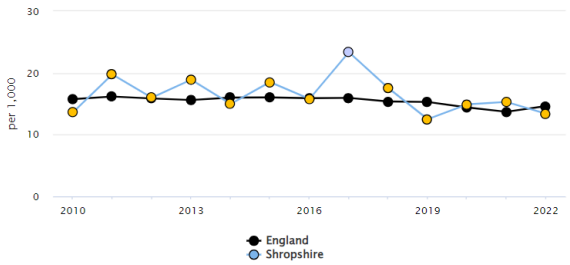
Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	8,346	14.6	14.3	14.9
West Midlands region (statistical)	↓	821	13.1	12.2	14.0
Telford and Wrekin	→	30	15.2	10.3	21.8
Stoke-on-Trent	→	45	14.9	10.8	19.9
Worcestershire	→	78	14.8	11.7	18.5
Solihull	→	27	13.8	9.1	20.1
Staffordshire	→	109	13.7	11.3	16.6
Shropshire	→	34	13.4	9.3	18.7
Wolverhampton	→	44	13.4	9.7	18.0
Coventry	→	53	13.2	9.9	17.2
Dudley	→	44	12.9	9.4	17.3
Birmingham	→	185	12.9	11.1	14.9
Warwickshire	→	68	11.9	9.3	15.1
Walsall	→	41	11.8	8.5	16.0
Sandwell	→	47	10.9	8.0	14.5
Herefordshire	→	16	10.6	6.1	17.2

Multiple births rate per 1,000 in Shropshire including nearest statistical neighbours, with West Midlands and England comparisons, 2022. Source: Child and Maternal Health Profile, Fingertips, OHID

Multiple births **New data** 2022 — Crude rate - per 1,000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↓	-	8,346	14.6	14.3	14.9
Neighbours average	–	-	313	14.3*	12.8	16.0
Somerset Cty	→	5	75	15.8	12.4	19.8
Wiltshire	→	4	68	15.3	11.9	19.4
Devon	→	1	85	14.0	11.2	17.3
Dorset	→	3	35	13.5	9.4	18.8
Shropshire	→	-	34	13.4	9.3	18.7
Herefordshire	→	2	16	10.6	6.1	17.2

Multiple births rate per 1,000 in Shropshire, with West Midlands and England comparisons, 2010 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
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

Source: OHID, based on Office for National Statistics data

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 2022, of all babies, 6.4% (165) were found to be of low birth weight which is similar to England (7.2%) but was the lowest in the region and significantly below the West Midlands average (7.8%) and all of its nearest statistical neighbours. Shropshire's percentage for low birth weight babies has been either statistically similar, or significantly lower than England, between 2011 and 2022.

Percentage of low of birth weight of babies in Shropshire, including regional neighbours, with West Midlands and England comparisons, 2022. Source: Child and Maternal Health Profile, Fingertips, OHID

Low birth weight of all babies **New data** 2022 — Proportion - %

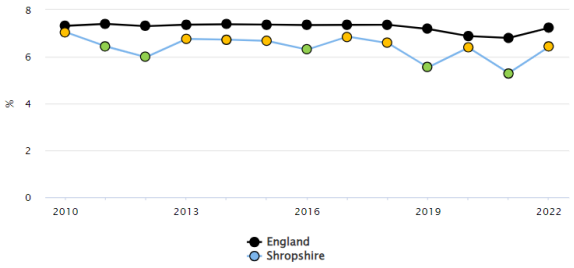
Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	40,762	7.2	7.2	7.3
West Midlands region (statistical)	↓	4,915	7.8	7.6	8.0
Birmingham	→	1,396	9.6	9.2	10.1
Sandwell	→	391	9.0	8.2	9.9
Walsall	↓	292	8.4	7.5	9.3
Coventry	↓	302	7.7	6.9	8.6
Wolverhampton	→	254	7.7	6.8	8.6
Dudley	→	264	7.7	6.8	8.6
Solihull	→	141	7.1	6.1	8.4
Worcestershire	↓	368	6.9	6.2	7.6
Herefordshire	→	104	6.9	5.7	8.2
Stoke-on-Trent	↓	203	6.8	6.0	7.8
Staffordshire	→	537	6.8	6.2	7.3
Telford and Wrekin	→	131	6.6	5.6	7.8
Warwickshire	→	367	6.5	5.8	7.1
Shropshire	→	165	6.4	5.5	7.4

Percentage of low of birth weight of babies in Shropshire, including statistical neighbours, with England comparison, 2022. Source: Child and Maternal Health Profile, Fingertips, OHID

Low birth weight of all babies **New data** 2022 — Proportion - %

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	→	-	40,762	7.2	7.2	7.3
Neighbours average	–	-	1,324	6.0*	5.7	6.4
Dorset	→	3	184	7.1	6.2	8.2
Herefordshire	→	2	104	6.9	5.7	8.2
Shropshire	→	-	165	6.4	5.5	7.4
Somerset Cty	→	5	281	5.9	5.2	6.6
Wiltshire	→	4	258	5.8	5.2	6.6
Devon	↓	1	332	5.5	5.0	6.1

Percentage of very low of birth weight babies in Shropshire, including West Midlands and England comparisons, 2010–22. 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%	6.3%*	7.3%
2011		186	6.4%	5.6%	7.4%	6.3%*	7.4%
2012		174	6.0%	5.2%	6.9%	6.6%*	7.3%
2013		191	6.8%	5.9%	7.7%	6.6%*	7.4%
2014		190	6.7%	5.9%	7.7%	6.6%*	7.4%
2015		187	6.7%	5.8%	7.7%	6.7%*	7.4%
2016		186	6.3%	5.5%	7.2%	6.4%*	7.3%
2017		192	6.9%	6.0%	7.9%	6.4%*	7.4%
2018		179	6.6%	5.7%	7.6%	6.9%*	7.4%
2019		143	5.5%	4.7%	6.5%	6.1%*	7.2%
2020		164	6.4%	5.5%	7.4%	6.2%*	6.9%
2021		140	5.3%	4.5%	6.2%	6.0%*	6.8%
2022		165	6.4%	5.5%	7.4%	6.0%*	7.2%

Source: OHID. based on Office for National Statistics data

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 2022, of all babies, 1.4% (35) were found to be of very low birth weight which is similar to England (1.0%) and the West Midlands average (1.3%) and 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 2022, besides 2019 when it was significantly lower.

Percentage of very low of birth weight of babies in Shropshire, including regional neighbours, with West Midlands and England comparisons, 2022. Source: Child and Maternal Health Profile, Fingertips, OHID

Very low birth weight of all babies **New data** 2022 — Proportion - %

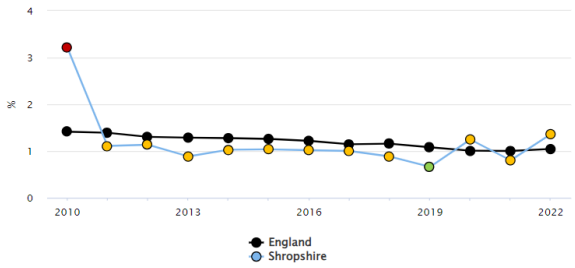
Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	5,890	1.0	1.0	1.1
West Midlands region (statistical)	↓	806	1.3	1.2	1.4
Sandwell	→	87	2.0	1.6	2.5
Birmingham	→	264	1.8	1.6	2.1
Shropshire	→	35	1.4	1.0	1.9
Wolverhampton	→	42	1.3	0.9	1.7
Walsall	→	43	1.2	0.9	1.7
Worcestershire	→	64	1.2	0.9	1.5
Staffordshire	→	92	1.2	0.9	1.4
Dudley	→	37	1.1	0.8	1.5
Telford and Wrekin	→	21	1.1	0.7	1.6
Warwickshire	→	46	0.8	0.6	1.1
Solihull	→	16	0.8	0.5	1.3
Stoke-on-Trent	↓	24	0.8	0.5	1.2
Herefordshire	→	11	0.7	0.4	1.3
Coventry	↓	24	0.6	0.4	0.9

Percentage of very low of birth weight of babies in Shropshire, including statistical neighbours, with England comparison, 2022. Source: Child and Maternal Health Profile, Fingertips, OHID

Very low birth weight of all babies **New data** 2022 — Proportion - %

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↓	-	5,890	1.0	1.0	1.1
Neighbours average	–	-	205	0.9*	0.8	1.1
Shropshire	→	-	35	1.4	1.0	1.9
Dorset	→	3	34	1.3	0.9	1.8
Somerset Cty	→	5	44	0.9	0.7	1.2
Devon	→	1	49	0.8	0.6	1.1
Herefordshire	→	2	11	0.7	0.4	1.3
Wiltshire	→	4	32	0.7	0.5	1.0

Percentage of very low of birth weight babies in Shropshire, including West Midlands and England comparisons, 2010–22. 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%

Source: OHID, based on Office for National Statistics data

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[32]. 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 2020-22, there were 22 stillbirths (fetal deaths occurring after 24 weeks of gestation) in Shropshire[33]. This equates to a rate of 2.8 per 1,000 births. This rate was the second lowest regionally, 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 its statistical neighbours as shown in the figure below.

32 Child and Maternal Health - Data - OHID (phe.org.uk)
33 Child and Maternal Health - Data - OHID (phe.org.uk)

Stillbirth rate per 1,000 births in Shropshire, including regional neighbours, with West Midlands and England comparisons, 2020-22. Source: Child and Maternal Health Profile, Fingertips, OHID

Stillbirth rate 2020 - 22 — Crude rate - per 1,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	6,958	3.9	3.8	4.0
West Midlands region (statistical)	–	840	4.4	4.1	4.7
Sandwell	–	76	5.9	4.6	7.3
Birmingham	–	240	5.4	4.8	6.2
Coventry	–	65	5.4	4.1	6.8
Warwickshire	–	82	4.7	3.7	5.8
Walsall	–	44	4.2	3.1	5.6
Wolverhampton	–	41	4.2	3.0	5.7
Worcestershire	–	65	4.0	3.1	5.1
Dudley	–	41	4.0	2.8	5.4
Stoke-on-Trent	–	35	3.8	2.7	5.3
Telford and Wrekin	–	21	3.5	2.2	5.4
Herefordshire	–	16	3.5	2.0	5.6
Staffordshire	–	79	3.2	2.6	4.0
Shropshire	–	22	2.8	1.8	4.3
Solihull	–	13	2.1	1.1	3.6

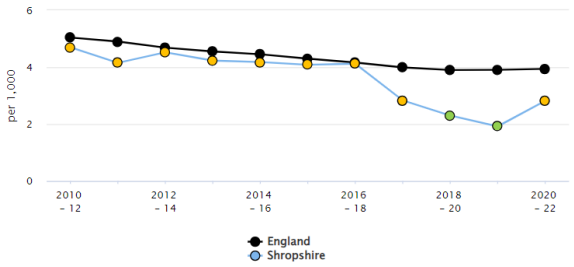
Stillbirth rate per 1,000 births in Shropshire, including statistical neighbours, with England comparison, 2020-22. Source: Child and Maternal Health Profile, Fingertips, OHID

Stillbirth rate 2020 - 22 — Crude rate - per 1,000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	6,958	3.9	3.8	4.0
Neighbours average	–	-	-	-	-	-
Dorset	–	3	29	3.6	2.4	5.2
Devon	–	1	67	3.5	2.7	4.4
Herefordshire	–	2	16	3.5	2.0	5.6
Shropshire	–	-	22	2.8	1.8	4.3
Wiltshire	–	4	34	2.5	1.7	3.5
Somerset Cty	–	5	-	-	-	-

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 increased in 2020-22. The rates in 2018-20 and 2019-21 were significantly below England's. Overall, the national and regional rate has been declining since 2010-12.

Stillbirth rate in Shropshire, including West Midlands and England comparisons, 2010-12 to 2020-22. 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
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

Source: OHID, based on Office for National Statistics data

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. In the period 2022-23, data has not been published for Shropshire, as OHID have identified a HES data quality issue affecting the Shrewsbury and Telford Hospital NHS Trust as they did not submit complete HES maternity data for the financial year ending 2023. In England the rate was 84.8 and the West Midlands 92.9. Prior to this year, 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, including regional neighbours, with West Midlands and England comparisons, 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID

Admissions of babies under 14 days 2022/23 — Crude rate - per 1,000

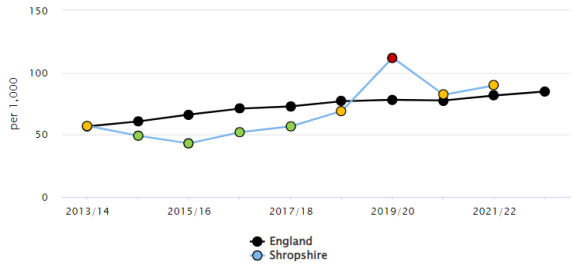
Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↑	43,740	84.8	84.1	85.6
West Midlands region (statistical)	↑	5,055	92.9	90.4	95.5
Walsall	↑	555	223.3	204.9	242.5
Stoke-on-Trent	↑	595	203.1	187.4	220.4
Staffordshire	↑	965	127.8	119.6	135.8
Wolverhampton	↑	300	97.9	87.7	110.2
Sandwell	→	390	97.1	88.0	107.5
Warwickshire	↑	490	92.0	83.7	100.1
Herefordshire	→	125	85.6	72.6	103.6
Solihull	→	150	81.7	69.7	96.5
Birmingham	↓	870	62.6	58.4	66.7
Coventry	↓	225	58.7	50.8	66.4
Worcestershire	↓	245	51.0	44.7	57.6
Dudley	→	150	46.6	39.4	54.6
Shropshire	↑	-	*	-	-
Telford and Wrekin	↑	-	*	-	-

Admissions of babies under 14 days per 1,000 in Shropshire, including statistical neighbours, with England comparison, 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID

Admissions of babies under 14 days 2022/23 — Crude rate - per 1,000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↑	-	43,740	84.8	84.1	85.6
Neighbours average	–	-	-	-	-	-
Dorset	→	3	210	89.0	77.7	102.3
Herefordshire	→	2	125	85.6	72.6	103.6
Wiltshire	↑	4	305	72.1	64.0	80.4
Devon	↓	1	400	59.6	53.8	65.6
Shropshire	↑	-	-	*	-	-
Somerset Cty	↓	5	-	-	-	-

Admissions of babies under 14 days per 1,000 in Shropshire, including West Midlands and England comparisons, 2013-14 to 2022-23. 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		145	57.2	49.0	68.2	60.7	56.7
2014/15		120	49.2	40.8	58.8	59.6	60.7
2015/16		110	43.1	36.1	52.7	63.7	66.3
2016/17		135	52.0	43.6	61.6	68.3	71.0
2017/18		135	56.7	46.8	66.2	71.4	72.8
2018/19		160	69.1	58.1	79.8	76.7	77.0
2019/20		255	112.1	99.1	127.1	82.7	78.1
2020/21		185	82.2	71.2	95.5	82.6	77.6
2021/22		195	89.7	76.6	102.1	86.2	81.6
2022/23		-	*	-	-	92.9	84.8

Source: OHID, based on NHS England data

Male Healthy life expectancy at birth

This indicator is an extremely important summary measure of mortality and morbidity in itself. Healthy life expectancy shows the years a person can expect to live in good health (rather than with a disability or in poor health).

It complements the supporting indicators by showing the overall trends in a major population health measure, setting the context in which local authorities can assess the other indicators and identify the drivers of healthy life expectancy.

A measure of the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health. The prevalence of good health is derived from responses to a survey question on general health. For a particular area and time period, it is an estimate of the average number of years a newborn baby would live in good general health if he or she experienced the age-specific mortality rates and prevalence of good health for that area and time period throughout his or her life. Figures are calculated from deaths from all causes, mid-year population estimates, and self-reported general health status, based on data aggregated over a three-year period. Figures reflect the prevalence of good health and mortality among those living in an area in each time period, rather than what will be experienced throughout life among those born in the area. The figures are not therefore the number of years a baby born in the area could actually expect to live in good general health, both because the health prevalence and mortality rates of the area are likely to change in the future and because many of those born in the area will live elsewhere for at least some part of their lives.

In the period 2018-20, healthy male life expectancy in Shropshire was 62.8 years, which was the sixth highest regionally, significantly similar to the regional figure of 61.9 and the national figure of 63.1. Shropshire was second lowest among its statistical neighbours, but statistically similar.

Male healthy life expectancy in Shropshire, including regional neighbours, with West Midlands and England comparisons, 2018-20. Source: Child and Maternal Health Profile, Fingertips, OHID

Healthy life expectancy at birth (Male) 2018 - 20

Life expectancy - Years

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	63.1	62.9	63.3
West Midlands region (statistical)	–	-	61.9	61.3	62.4
Solihull	–	-	67.4	65.7	69.2
Worcestershire	–	-	65.3	63.6	67.1
Herefordshire	–	-	64.2	62.3	66.1
Staffordshire	–	-	63.1	61.4	64.8
Dudley	–	-	62.9	60.8	65.0
Shropshire	–	-	62.8	60.7	64.9
Warwickshire	–	-	62.1	60.0	64.2
Sandwell	–	-	61.6	59.4	63.7
Coventry	–	-	61.1	59.0	63.1
Wolverhampton	–	-	60.0	58.2	61.9
Birmingham	–	-	59.2	57.5	60.8
Walsall	–	-	59.0	57.1	60.9
Telford and Wrekin	–	-	57.6	55.4	59.8
Stoke-on-Trent	–	-	55.9	53.9	57.9

Male healthy life expectancy in Shropshire, including statistical neighbours, with England comparison, 2018-20. Source: Child and Maternal Health Profile, Fingertips, OHID

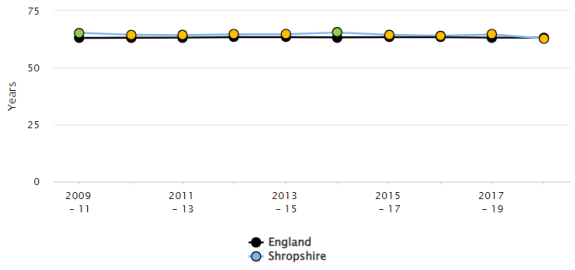
Healthy life expectancy at birth (Male) 2018 - 20

Life expectancy - Years

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	-	63.1	62.9	63.3
Neighbours average	–	-	-	-	-	-
Devon	–	1	-	66.6	64.9	68.3
Wiltshire	–	4	-	66.5	64.7	68.4
Herefordshire	–	2	-	64.2	62.3	66.1
Somerset Cty	–	5	-	64.2	62.3	66.1
Shropshire	–	-	-	62.8	60.7	64.9
Dorset	–	3	-	62.6	60.4	64.8

As shown in the figure below, Shropshire's healthy life expectancy for males has mainly been statistically similar to England's, however 2018-20 was the lowest it has been going back to 2009-11.

Male healthy life expectancy in Shropshire, including West Midlands and England comparisons, 2009-11 to 2018-20. 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
2009 - 11		-	65.3	63.8	66.8	-	63.0
2010 - 12		-	64.4	62.9	66.0	-	63.2
2011 - 13		-	64.3	62.7	65.8	-	63.2
2012 - 14		-	64.7	63.0	66.3	-	63.4
2013 - 15		-	64.7	63.0	66.4	-	63.4
2014 - 16		-	65.4	63.6	67.1	-	63.3
2015 - 17		-	64.5	62.6	66.3	-	63.4
2016 - 18		-	64.0	62.1	65.9	-	63.4
2017 - 19		-	64.6	62.9	66.3	-	63.2
2018 - 20		-	62.8	60.7	64.9	-	63.1

Source: Office for National Statistics

Ectopic pregnancy admissions rate per 100,000

Ectopic pregnancy is a serious condition that usually results in hospital admission. Pelvic inflammatory disease (PID) is a clinical syndrome referring to infection and inflammation of the upper female genital tract which may lead to serious complications such as ectopic pregnancy and tubal factor infertility. Both PID and ectopic pregnancy have a multi-factorial aetiology although chlamydial infection and other sexually transmitted infections are considered to be major causes of both conditions.

This is defined as the rate of ectopic pregnancy admissions to hospital in women aged 15-44 years per 100,000 population (women aged 15-44 years). In the period 2022-23, there were 35 admissions for ectopic pregnancy in Shropshire, which equates to a rate of 70.3 per 100,000, which was the lowest rate in the West Midlands region but was statistically similar to the West Midlands and England rates. This rate was the third lowest among its statistical neighbours as shown in the figure below.

Ectopic pregnancy admissions rate per 100,000 in Shropshire, including regional neighbours, with West Midlands and England comparisons, 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID

Ectopic pregnancy admissions rate / 100,000 2022/23 — Crude rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↑	9,897	89.0	87.3	90.8
West Midlands region (statistical)	→	1,115	97.4	91.7	103.2
Walsall	→	75	135.0	106.2	169.2
Stoke-on-Trent	→	65	128.4	99.1	163.6
Wolverhampton	→	65	122.4	96.1	158.1
Herefordshire	→	35	121.7	84.8	169.3
Worcestershire	→	125	120.8	100.5	143.9
Solihull	→	45	118.9	82.2	153.0
Dudley	→	65	110.0	87.9	144.0
Telford and Wrekin	→	35	97.1	72.3	141.5
Staffordshire	→	145	96.0	79.8	111.6
Sandwell	→	65	92.7	70.3	116.5
Coventry	→	65	82.8	65.0	107.0
Birmingham	→	210	80.4	70.6	92.9
Warwickshire	→	85	77.5	60.3	93.8
Shropshire	→	35	70.3	45.6	93.1

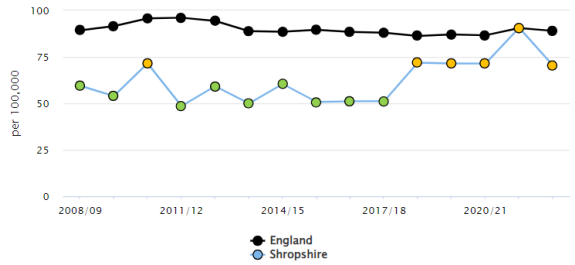
Ectopic pregnancy admissions rate per 100,000 in Shropshire, including statistical neighbours, with England comparison, 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID

Ectopic pregnancy admissions rate / 100,000 2022/23 — Crude rate - per 100,000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↑	-	9,897	89.0	87.3	90.8
Neighbours average	–	-	-	-	-	-
Herefordshire	→	3	35	121.7	84.8	169.3
Cheshire East	→	15	70	103.1	80.4	130.2
East Riding of Yorkshire	→	6	50	95.9	72.8	128.6
Dorset	→	12	50	93.7	69.6	123.6
Somerset UA	→	4	85	93.0	73.3	113.8
Gloucestershire	→	9	105	92.3	75.5	111.8
West Berkshire	→	13	25	89.5	63.7	140.7
Northumberland	→	10	40	80.8	56.0	107.6
Suffolk	→	8	100	78.6	63.9	95.6
Cumberland	→	7	35	77.8	57.9	113.4
Wiltshire	→	2	65	76.9	60.4	99.3
North Yorkshire UA	→	1	70	73.4	58.1	93.9
Devon	→	14	95	70.9	56.0	85.1
Shropshire	→	-	35	70.3	45.6	93.1
Cornwall	→	11	60	64.9*	48.6	82.4
Westmorland and Furness	→	5	20	57.8	35.3	89.3

As shown in the figure below, Shropshire's admission rate for ectopic pregnancy has been statistically similar to England's for the last five years, with a drop in 2022-23 from 2021-22. Before this, Shropshire was significantly below England, which has remained broadly steady.

Ectopic pregnancy admissions rate per 100,000, including West Midlands and England comparisons, 2008-09 to 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID



Recent trend: ➡ No significant change

Period		Shropshire Count	Value	95% Lower CI	95% Upper CI	England
2008/09	🟢	31	59.5	40.4	84.4	89.3
2009/10	🟢	28	53.9	35.8	77.9	91.6
2010/11	🟡	37	71.5	50.3	98.5	95.7
2011/12	🟢	25	48.6	33.0	74.0	96.1
2012/13	🟢	30	59.2	36.7	79.8	94.4
2013/14	🟢	25	50.0	33.9	76.1	88.8
2014/15	🟢	30	60.4	37.4	81.5	88.5
2015/16	🟢	25	50.7	32.8	74.9	89.6
2016/17	🟢	25	51.1	34.7	77.9	88.4
2017/18	🟢	25	51.1	31.5	73.1	88.0
2018/19	🟡	35	71.9	51.8	102.4	86.3
2019/20	🟡	35	71.5	46.4	94.6	87.1
2020/21	🟡	35	71.4	48.0	97.0	86.6
2021/22	🟡	45	90.7	62.7	116.7	90.5
2022/23	🟡	35	70.3	45.6	93.1	89.0

Source: OHID, based on NHS England and Office for National Statistics data

Additional data

Live births

According to the NOMIS website which contains official census and labour market statistics, in 2022 there were 2,567 live births in Shropshire: a small fall from 2,639 in 2021, and the lowest number in the last 5 years [34]. The number of live births was highest in Bayston Hill, Column and Sutton Ward (113), Oswestry East (98) and Shifnal South and Cosford (85)[35].

Live births in Shropshire by electoral ward, 2022. Source: Live births in England and Wales for small geographical areas, NOMIS [35]

Electoral wards	Live births in 2022	Percentage of live births
Bayston Hill, Column and Sutton	113	4.4%
Oswestry East	98	3.8%
Shifnal South and Cosford	85	3.3%
Market Drayton West	77	3.0%
Battlefield	71	2.8%
Shifnal North	69	2.7%
Whitchurch North	66	2.6%
Gobowen, Selattyn and Weston Rhyn	63	2.5%
Wem	58	2.3%
Bowbrook	53	2.1%
Bridgnorth West and Tasley	50	1.9%
Church Stretton and Craven Arms	50	1.9%
Cheswardine	49	1.9%

[34] NOMIS Live births
[35] Live births in England and Wales for small geographical areas

Market Drayton East	49	1.9%
Sundorne	49	1.9%
Radbrook	48	1.9%
Tern	48	1.9%
Castlefields and Ditherington	47	1.8%
Bagley	45	1.8%
Prees	45	1.8%
Broseley	42	1.6%
Harlescott	42	1.6%
Severn Valley	42	1.6%
Shawbury	42	1.6%
St Martin's	42	1.6%
Oswestry South	40	1.6%
Clee	39	1.5%
Ellesmere Urban	37	1.4%
Monkmoor	37	1.4%
Rea Valley	37	1.4%
Whittington	37	1.4%
Abbey	36	1.4%
Meole	36	1.4%
Porthill	36	1.4%
Burnell	35	1.4%
Oswestry West	35	1.4%
Quarry and Coton Hill	35	1.4%
Ludlow South	34	1.3%
St Oswald	34	1.3%
Cleobury Mortimer	33	1.3%
Highley	33	1.3%
Ruyton and Baschurch	33	1.3%
Albrighton	32	1.2%
Llanymynech	32	1.2%
The Meres	31	1.2%
Loton	30	1.2%
Longden	29	1.1%
Copthorne	28	1.1%
Whitchurch South	28	1.1%
Bridgnorth East and Astley Abbotts	27	1.1%
Underdale	27	1.1%
Corvedale	26	1.0%
Ludlow East	26	1.0%
Belle Vue	25	1.0%
Ludlow North	25	1.0%
Clun	22	0.9%
Hodnet	22	0.9%
Worfield	21	0.8%
Brown Clee	20	0.8%
Chirbury and Worthen	18	0.7%
Alveley and Claverley	16	0.6%
Bishop's Castle	16	0.6%
Much Wenlock	16	0.6%
Total live births in 2022	2,567	

Age of mothers

In 2022, there were more live births (902, 35.1%) 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 (32.7%) and England average (34.3%) [36]. In 2022 in Shropshire, 57.4% of mothers were aged over 30, higher than the regional figure of 54.5% but lower than the national average of 59.8%.

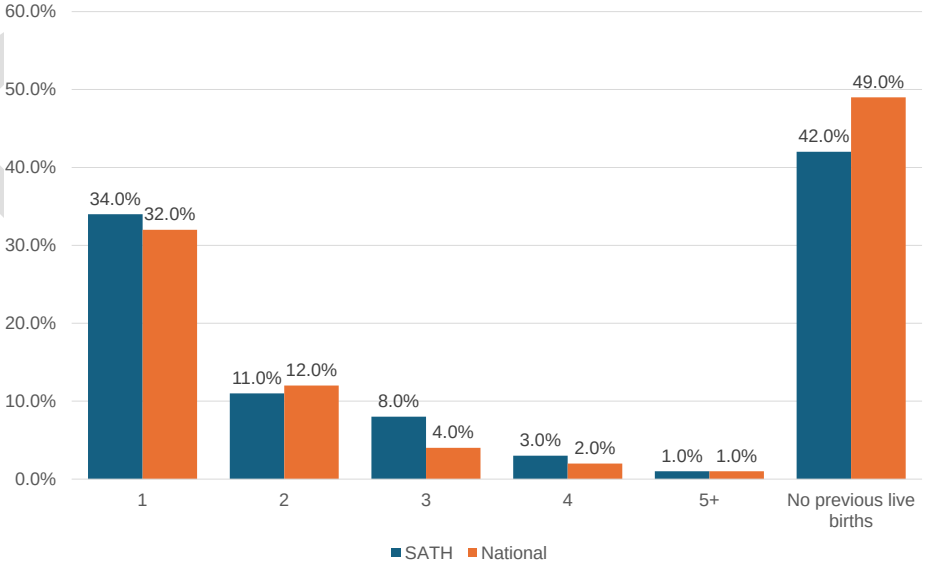
Live births in Shropshire, West Midlands and England by age of mother, 2022. Source: Live births in England and Wales down to local authority local area, NOMIS [36]

Age of mother	Shropshire live births	Shropshire	West Midlands	England
Mother aged under 20	75	2.9%	3.0%	2.4%
Mother aged under 18	11	0.4%	0.7%	0.6%
Mother aged 20-24	328	12.8%	14.0%	11.9%
Mother aged 25-29	691	26.9%	28.5%	25.9%
Mother aged 30-34	902	35.1%	32.7%	34.3%
Mother aged 35-39	484	18.9%	17.5%	20.3%
Mother aged 40-44	82	3.2%	3.9%	4.8%
Mother aged 45 and over	5	0.2%	0.3%	0.4%
Age of mother unknown or not stated	0	0.0%	0.0%	0.0%
Mother aged 30 or over	1,473	57.4%	54.5%	59.8%
Total	2,567	2,567	63,368	577,046

Mother's previous births

Between April 2023 and March 2024, 42% of mothers at SATH had no previous live births, slightly below the national figure of 49%, meanwhile 34% of mothers had one previous live birth and 11% had 2 previous live births[37].

Mother's previous births, Shrewsbury and Telford Hospital compared to the national average, April 2023 to March 2024. Source: National Maternity Dashboard, NHS England.



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

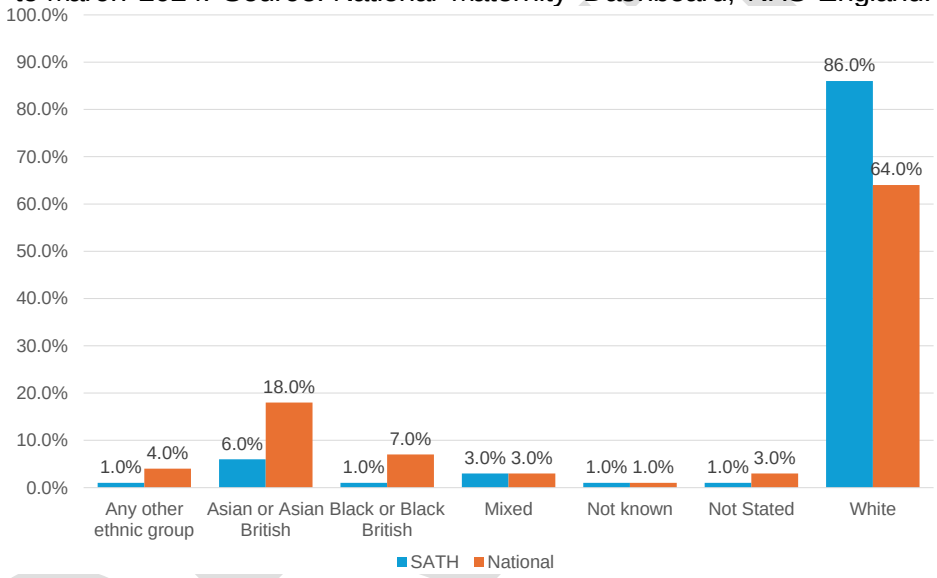
[36] NOMIS - Live births in England and Wales down to local authority area
[37] National Maternity dashboard

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

Between April 2023 and March 2024, 86% of mothers in Shropshire were classified as 'White', which was above the national figure of 64%. During the same period, 11% of mothers reported themselves as belonging to Black or ethnic minority communities, below the national average of 32% [38].

Ethnicity of mother, Shrewsbury and Telford Hospital compared to the national average, April 2023 to March 2024. 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,
- a recent migrant, asylum seeker or refugee,
- has difficulty reading or speaking English, and
- misuse substances including alcohol and drugs.

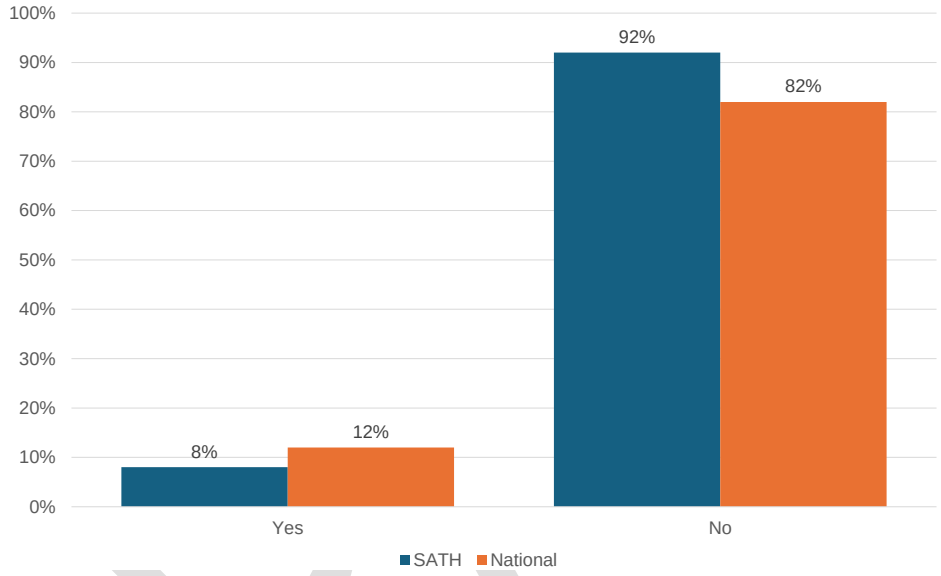
Women in these groups may have additional needs which should be considered when planning services. For example, women aged under 20 can be reluctant to use antenatal

[38] National Maternity dashboard

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, 8% of women attending booking appointments at SATH had complex social factors, which is lower than the 12% nationally.

Complex Social Factors, Shrewsbury and Telford Hospital compared to the national average, April 2023 to March 2024. 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,

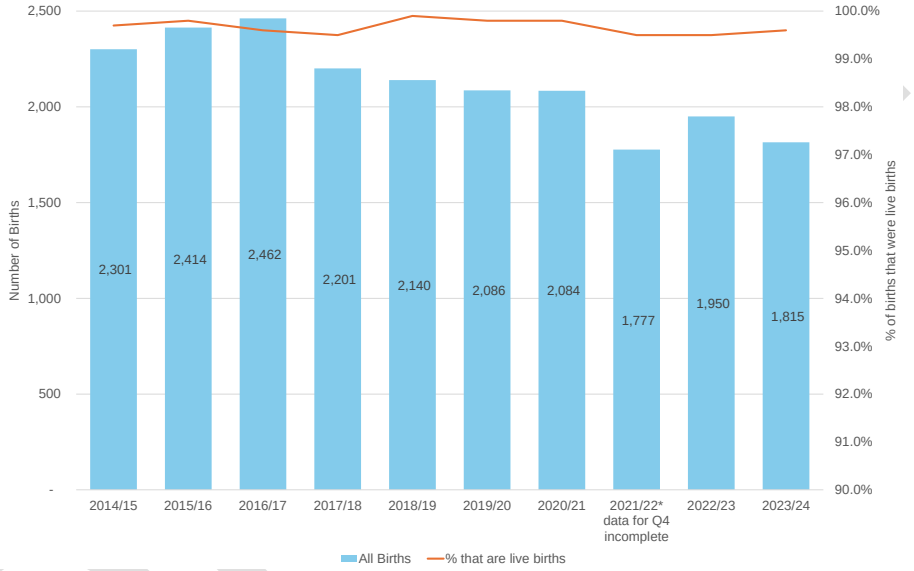
As with smoking, deprivation was found to be a clear driver of complex social factors with 15% of mothers living within the most deprived neighbourhoods (IMD2019) identified as having a complex social factor at their first antenatal booking, compared to just 3% of mothers from the least deprived neighbourhood. 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

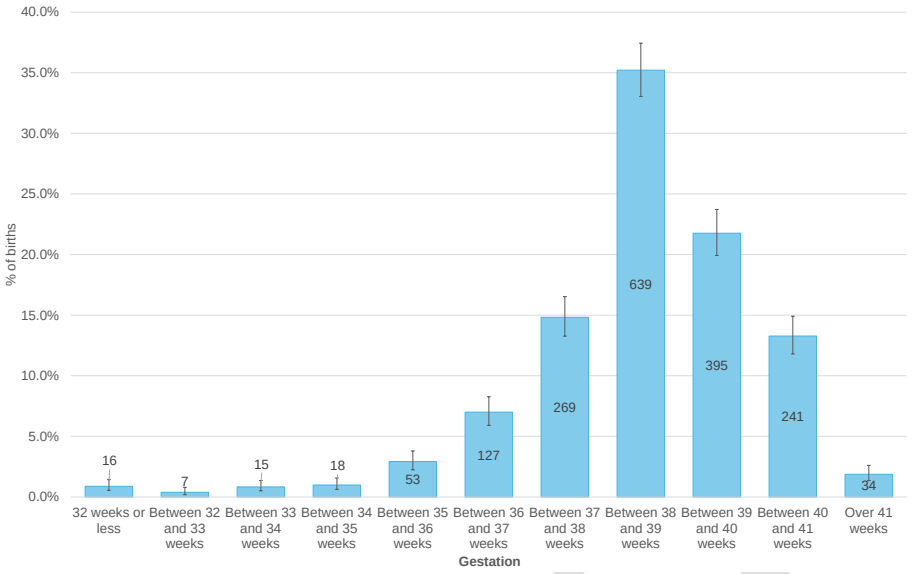


*data for Quarter 4 2021/22 was incomplete due to a change in the maternity database

Gestation

Of the 1,815 births within SATH in 2023-24, 35% of them of them occurred between 38- and 39-weeks' gestation, with 21.8% occurring between 39 and 40 weeks. 3.1% (56 deliveries) had a gestation of under 35 weeks, including 0.9% (16 deliveries) under 32 weeks, in contrast 1.9% (34 deliveries) had a gestation of over 41 weeks.

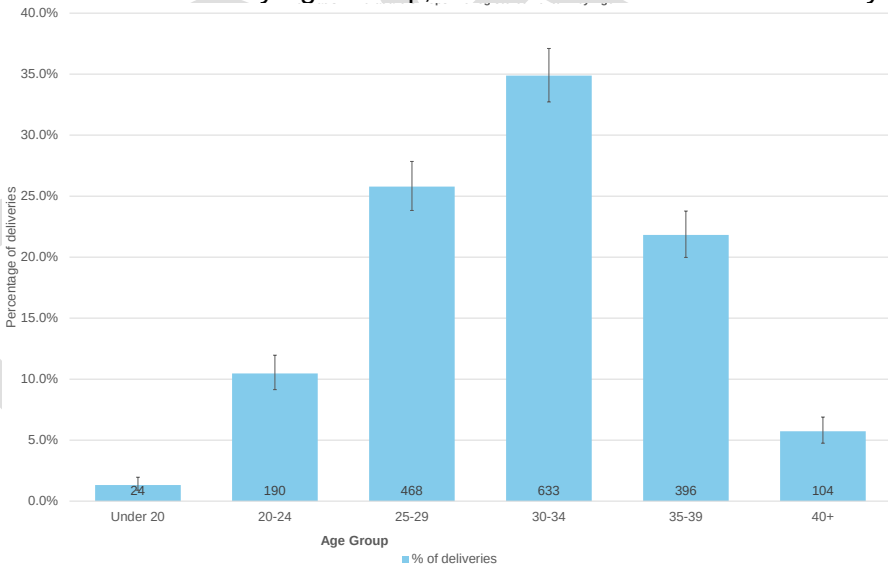
Shropshire births within SATH by number of weeks gestation, 2023/24. Source: SATH maternity database



Age of Mother

In 2023-24, over a third of births that occurred at SATH were mothers aged 30-34 (34.9%, 633 deliveries), with 25.8% from those aged 25-29 and 21.8% from those aged 35-39 and there were 104 births for mothers aged over 40, 24 from mothers aged under 20.

Shropshire births within SATH by Age Group, 2023/24. Source: SATH maternity database

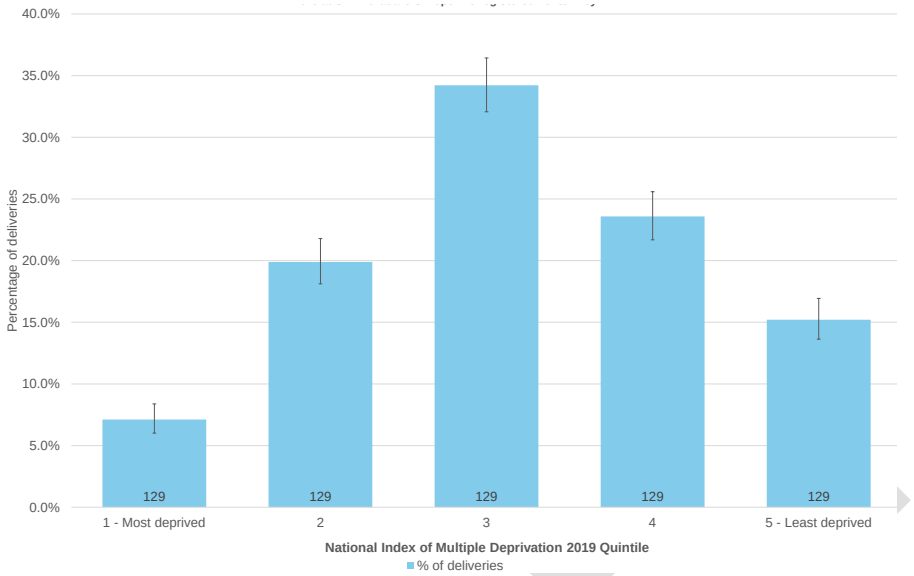


Deprivation

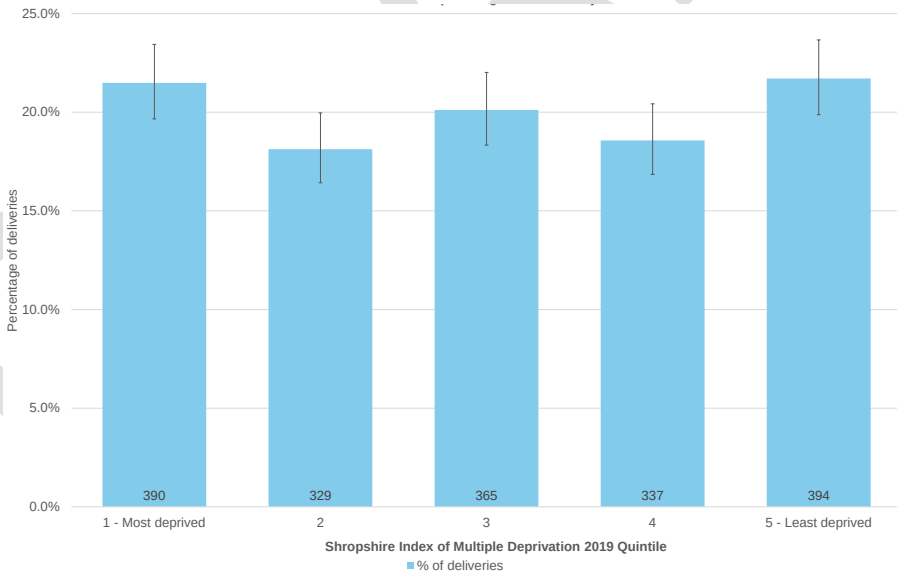
There are several health outcomes that have been found to be worse in mothers and babies from more deprived communities. Analysis of the SATH births in 2023-24 allowed analysis of the index of multiple deprivation 2019 (IMD) based upon the mother's postcode, this reveals that 34.2% of deliveries (621) came from the middle national quintile, whilst 7.1% (129) came from the most deprived national quintile. However, Shropshire is a relatively affluent county in comparison to other local authorities, so examining all the births by the Shropshire IMD quintile (i.e. comparing deprivation against other areas in Shropshire) shows a much

more even split between the quintiles – with 21.5% of births from the most deprived areas in Shropshire, whilst 21.7% were from the least deprived areas in Shropshire.

Shropshire births within SATH by National IMD 2019 Quintile, 2023/24. Source: SATH maternity database



Shropshire births within SATH by Shropshire IMD 2019 Quintile, 2023/24. 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 5 years (2019-20 to 2023-24), which meant a total of 9,712 deliveries – 42.7% were for mothers who lived in the Shrewsbury place plan area. Despite looking at 5 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, 2019-20 to 2023-24. Source: SATH maternity database

Place Plan Area	Number of deliveries	Percentage of deliveries
Albrighton	153	1.6%
Bishop's Castle	228	2.3%
Bridgnorth	544	5.6%
Broseley	155	1.6%
Church Stretton	171	1.8%
Cleobury Mortimer	28	0.3%
Craven Arms	232	2.4%
Ellesmere	148	1.5%
Highley	163	1.7%
Ludlow	207	2.1%
Market Drayton	705	7.3%
Much Wenlock	78	0.8%
Oswestry	876	9.0%
Pontesbury and Minsterley	202	2.1%
Shifnal	453	4.7%
Shrewsbury	4,146	42.7%
Wem	536	5.5%
Whitchurch	482	5.0%
Total	**9,712**	**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 from 2020-21 which looks at the percentage of live births whose first feed was breastmilk, in this time period Shropshire was the third highest percentage in the West Midlands with 74.8%, which was statistically higher than the West Midlands and England and Shropshire was the 9th highest among its nearest statistical neighbours. There is no trend data for this indicator, as it hasn't been updated

since 2020-21 and the definition of measuring breastfeeding has been altered in previous years.

Percentage of baby's whose first feed was breastmilk, including regional neighbours, with West Midlands and England comparisons, 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID

Baby's first feed breastmilk 2020/21

Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	269,625	71.7	71.6	71.8
West Midlands region (statistical)	–	36,255	68.3	67.9	68.7
Herefordshire	–	830	77.2	74.6	79.6
Warwickshire	–	3,125	76.3	75.0	77.6
Shropshire	–	1,675	74.8	73.1	76.6
Coventry	–	2,365	73.8	72.2	75.2
Birmingham	–	8,990	71.5	70.8	72.3
Solihull	–	1,200	70.0	67.7	72.0
Sandwell	–	2,460	68.7	67.1	70.1
Wolverhampton	–	1,750	67.0	65.3	68.9
Telford and Wrekin	–	1,215	66.0	63.9	68.3
Worcestershire	–	2,980	64.6	63.3	66.0
Dudley	–	2,095	64.4	62.8	66.1
Staffordshire	–	4,275	63.3	62.2	64.5
Stoke-on-Trent	–	1,610	60.2	58.3	62.0
Walsall	–	1,685	59.1	57.3	60.9

Percentage of baby's whose first feed was breastmilk, including statistical neighbours, with West Midlands and England comparisons, 2022-23. Source: Child and Maternal Health Profile, Fingertips, OHID

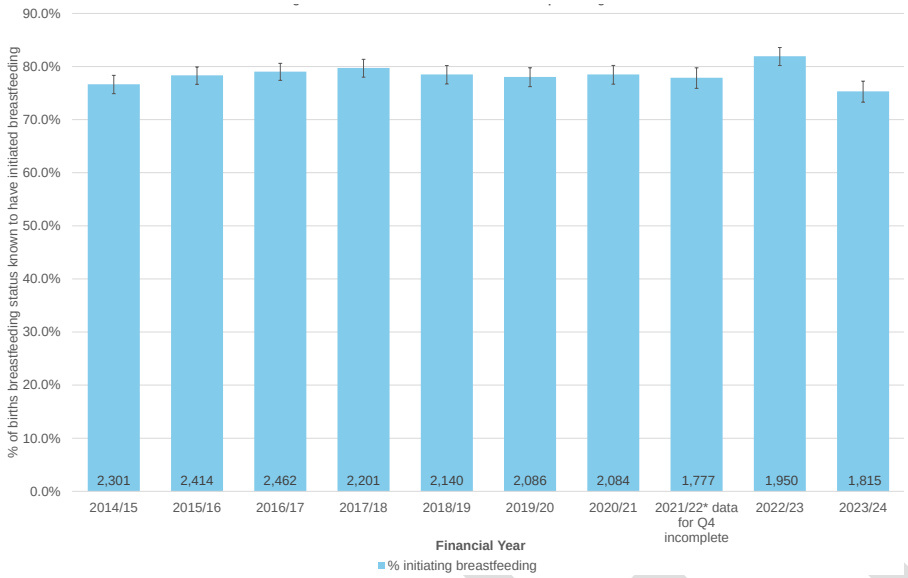
Baby's first feed breastmilk 2020/21

Proportion - %

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	269,625	71.7	71.6	71.8
Neighbours average	–	-	-	-	-	-
Gloucestershire	–	9	535	84.3	80.9	86.6
Somerset UA	–	4	1,275	83.9*	81.8	85.5
Cornwall	–	11	3,430	77.3*	76.1	78.5
Herefordshire	–	3	830	77.2	74.6	79.6
Suffolk	–	8	3,765	76.1	74.8	77.2
Cheshire East	–	15	915	75.9	73.4	78.2
West Berkshire	–	13	710	75.5	73.0	78.4
North Yorkshire UA	–	1	3,300	74.8*	73.5	76.1
Shropshire	–	-	1,675	74.8	73.1	76.6
Dorset	–	12	1,490	74.7	72.8	76.6
Wiltshire	–	2	1,715	73.6	71.8	75.4
East Riding of Yorkshire	–	6	1,660	72.8	70.8	74.5
Northumberland	–	10	1,380	66.0	63.9	67.9
Devon	–	14	3,195	62.4	61.0	63.7
Westmorland and Furness	–	5	-	-	-	-
Cumberland	–	7	-	-	-	-

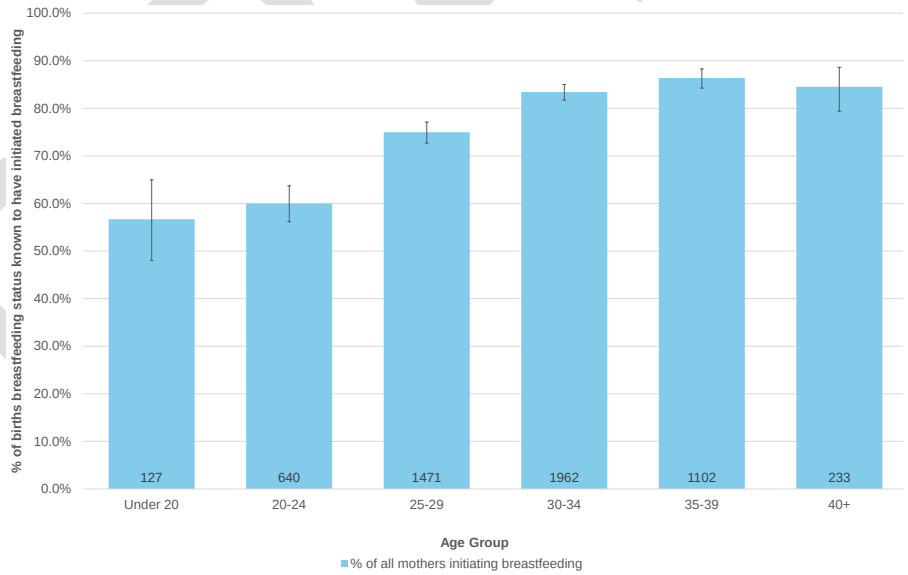
While there is some local maternity data that has been used, the data for breastfeeding doesn't follow the same definition as used by OHID – this will be rectified in future - but rather is in-line with the previously used definition the percentage of live births where breastfeeding status is known, where the mother initiated breastfeeding within the first 48 hours of birth (either by putting the baby to the breast or the baby being given any of the mothers breast milk). In the data going back to 2014-15 to 2023-24 Shropshire's breastfeeding initiation rates were over 75%, with a high of 81.9% in 2022-23

Percentage of mother's initiating breastfeeding within 48 hours of birth at SATH, 2014-15 to 2023-24. Source: SATH Maternity Database



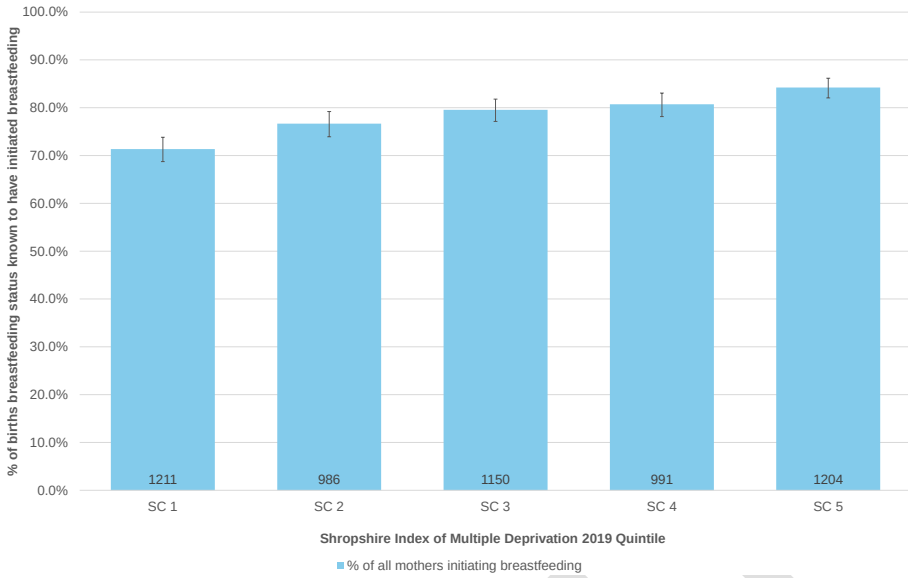
In looking at the three most recent years combined, there were higher rates of breastfeeding among older mothers, with the lowest breastfeeding in the under 20s (56.7%) and the 20-24 age group (60%), while rates in those aged over 30 were over 83%.

Percentage of mother's initiating breastfeeding within 48 hours of birth at SATH by age-group, 2021/22 to 2023/24. Source: SATH Maternity Database



There are also lower breastfeeding initiation rates as deprived increases, with the most deprived quintile (71.3%) significantly below the other quintiles, whilst the least deprived quintile had a initiation rate of 84.2%.

Percentage of mother's initiating breastfeeding within 48 hours of birth at SATH by Shropshire IMD2019 Quintile, 2021/22 to 2023/24. 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"[40], 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 by the domestic abuse project officer within Shropshire council from the SATH maternity department[39]. This revealed there were 45 pregnant 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 and 2023-24. 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 30-34 age group (33.3%) 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 two years by the same age groups, domestic violence was present in 1.1% of the 1,346 in the 30-34 age group. However, while there were only 10 cases of domestic violence in mothers aged under 25, this is would equate to 2.2% of the 462 deliveries in this age group [40]shown.

[39] Information request regarding domestic violence in maternity, SATH maternity database
[40] Supporting women and babies after domestic abuse, women's aid

Domestic violence indicator by age of mother, 2022-23 and 2023-24. Source: SATH maternity database

	Under 25	25-29	30-34	35 or more	Total
Domestic violence number	10	13	15	7	45
Percentage of domestic violence	22.2%	28.9%	33.3%	15.6%	100.0%
Total number of mothers who delivered	462	966	1,346	991	3,765
Domestic violence as a percentage of all mothers	2.2%	1.3%	1.1%	0.7%	1.2%

The women's aid's toolkit for domestic abuse specialists "supporting women and babies after domestic abuse"[40] 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 and 2023-24, where there were 3,765 deliveries, then that would equate to 753 to 1,129 women in Shropshire.

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.[41]

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.

[41] Public Health England. The Public Health Burden of Alcohol and the Effectiveness and Cost-Effectiveness of Alcohol Control Policies: An evidence review. PHE 2016.

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.[42]

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[43]. 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[44] [45]. 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 [46]. 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[47]. 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,

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[42] UK Chief Medical Officers' Low Risk Drinking Guidelines, 2016

[43] 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

[44]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

[45] 2015-17 https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202019%20-%20WEB%20VERSION.pdf

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

[47] 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/

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.

The percentage of pregnant women who self-reported drinking alcohol at the time of booking appointment with midwife was included in the OHID profile for pregnancy and birth, however, on a nationally in 2018/19, 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, although this was only available for mothers who delivered up to 2020-21. To ensure there is no risk of identification, 5 years of maternity data was combined (2016-17 to 2020-21) is shown in the table below. In this period 48.9% of women were apparently consuming no alcohol pre-pregnancy, with 4.2% (457 women) drinking over the recommended weekly 14 units. At the booking appointment, 96.7% 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, 2016-17 and 2020-21. 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	5,364	48.9%	10,612	96.7%
1 to 14 units	47,00	42.8%	90	0.8%
14 units or more	457	4.2%	5	0.0%
Not recorded	452	4.1%	266	2.4%
Total	**10,973**	**100.0%**	**10,973**	**100.0%**

Local data from the SATH maternity unit did though include self-reported data on the substance misuse status of the mother, although this was only available for mothers who delivered up to 2020-21. To ensure there is no risk of identification, 5 years of maternity data was combined (2016-17 to 2020-21) is shown in the table below. In this period 28 (0.3%) of women were apparently currently, while 469 (4.3%) had previously used, with 75.2% of women stating they had never used.

Substance Misuse status, for women that delivered at SATH, 2016-17 and 2020-21. Source: SATH maternity database

Substance Misuse status	**Number of women**	**% of women**
Currently using	28	0.3%
Never used	8,252	75.2%
Not stated	2,205	20.1%
Previously used	469	4.3%
(blank)	19	0.2%
Currently using	28	0.3%
Total	**10,973**	**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 Perpetratored To Domestic Violence Abuse	0	0.0%
Service User Currently Perpetratored To Domestic Violence Abuse	1	1.6%
Any recorded domestic violence (subject or perportated)	**12**	**18.8%**
Total	**64**	**100.0%**

Mental health (to follow)

Mental health involvement status, for women that delivered at SATH, 2016-17 and 2020-21. Source: SATH maternity database

Mental Health Involvement status	Number of women	% of women
Currently involved	441	4.0%
Previously involved	1,577	14.4%
None	8,922	81.3%
(blank)	**33**	0.3%
Total	**10,973**	**100.0%**

Mental health feelings, for women that delivered at SATH, 2016-17 and 2020-21. Source: SATH maternity database

Mother answered yes to	Number of women	% of women
Feeling down depressed or hopeless	102	0.9%
Feeling little interest / pleasure in doing things	43	0.4%
Feels she needs or wants help with low mood	101	0.9%
Feeling down depressed or hopeless	102	0.9%
Total	**10,973**	**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 Datateam

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 Datateam

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 Datateam

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 Datateam

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 personalised care for their individual needs and 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 regarding levels of repeat pregnancies 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?)
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 maternal obesity, smoking, safer sleeping, parenting support etc.	Healthy Pregnancy Team CDOP Review System Child Mortality Plan Healthy Weight Strategy	Healthy Lives Service – community to support family members in the home Early Help – increase referrals Family Foundations course – increase uptake Solihull Approach – antenatal course increase uptake Maternity service – antenatal education	LMNS System Quality Group Children's safeguarding Board HWBB

Area of need	Mitigation (What are we doing now?)	Recommendation (What are we intending to do and how?)	Governance (Where does this recommendation sit?)
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	Early help partnership board

END OF REPORT