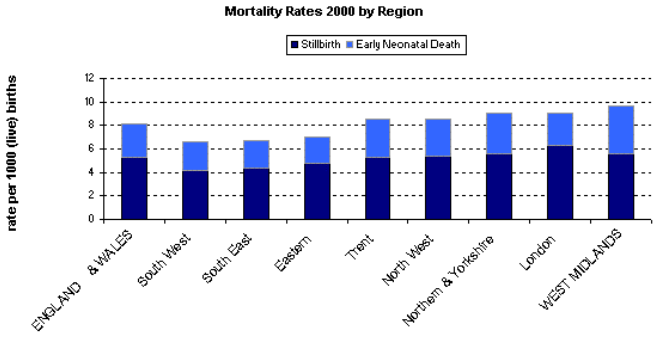
Summary of Regional Vital Statistics 2000

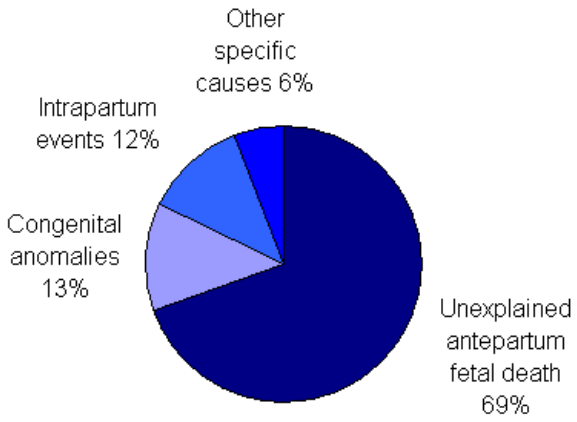
The number of births in the West Midlands has fallen by 2,012 from 63,857 to 61,845, a 3.2% reduction on the previous year compared with a 2.8% drop for England & Wales.

The perinatal mortality rate is 9.7/1000 births (597 cases) in the West Midlands. This is higher than the rate for England & Wales (8.1/1000 births), and of all other Health Regions.



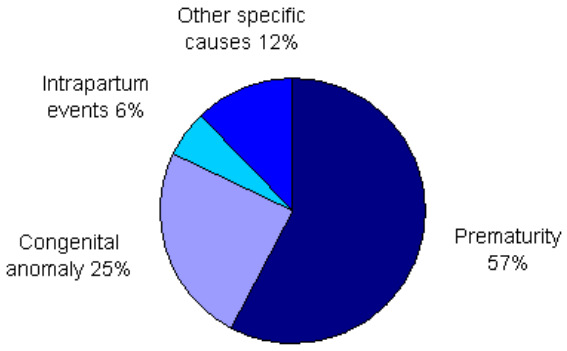
The stillbirth rate for 2000 is 5.6/1000 births (348 cases) in the West Midlands. This compares with a rate of 6.1/1000 births in 1999. The stillbirth rate in the West Midlands exceeds that for England & Wales, which is 5.2/1000 births. The regional rate is the second highest of all Health Regions. Analysis of cause of death by the Wigglesworth classification shows that the largest component of stillbirths is in the 'unexplained' category: 69% (up from 66% in 1999)

West Midlands Stillbirths 2000
Wigglesworth Cause of Death



West Midlands Early Neonatal Deaths 2000
Wigglesworth Cause of Death

The early neonatal death rate for the West Midlands in 2000 is 4.0/1000 live births (3.8/1000 live births in 1999). This remains higher than the early neonatal death rate for England and Wales (2.9/1000 live births), and is the highest of any region. The largest component of early neonatal mortality is 'prematurity' (57%).



Comment

The Perinatal Institute is engaged in an active campaign to identify avoidable causes and to introduce pro-active strategies. The following initiatives relate to the main categories of perinatal mortality:

1. **Congenital anomalies:** We are preparing introduction of the National Screening Committee's antenatal guidelines in the West Midlands. The project will establish standardised methods applied through a network of well-trained local co-ordinators. The first target is antenatal screening for Down's syndrome.

2. **'Unexplained' antepartum deaths**: This is again the single largest category of perinatal mortality. The Institute considers that many losses categorised as 'unexplained stillbirths' under the current, outdated classification are in fact potentially avoidable. We have developed a new classification system which identifies the Relevant Condition at Death (ReCoDe) and includes a category for fetal growth restriction. ReCoDe has identified that 63% of the 'unexplained' stillbirths had intrauterine growth failure before demise. Most of these deaths occur at gestations where the fetus would be mature enough to do well after induced delivery, if only the slow intrauterine growth was suspected and diagnosed in time (see Stillbirth in the West Midlands).

   The 8th CESDI Report was published in September 2001 (see www.cesdi.org.uk) and includes a detailed analysis of its 1:10 Stillbirths Enquiry (see Chapter 3) which also found that many of these deaths are potentially avoidable. Further sobering news comes from the EURONATAL Study (see Chapter 4, 8th CESDI Report), which concerns comparisons in perinatal care and outcome in ten areas in Europe. While methods of ascertainment varied, it was apparent that stillbirths in England had the highest rate of Grade 2/3 substandard care. Significantly, the investigators found a direct association between rates of substandard care and the levels of perinatal mortality. The single most frequent factor in sub-optimal care delivery was the failure of antenatal detection of intrauterine growth restriction.

   The Perinatal Institute has put forward recommendations for a region-wide introduction of a fetal growth screening programme. The Regional Directors of Public Health have agreed to support these proposals and Professor Rod Griffiths is endeavouring to secure a special allocation to fund this project.

3. **Intrapartum related deaths:** These seem to be in modest decline, which may be related to CESDI's repeated calls for better training in cardiotocography (CTG). Our CTG Tutor software package continues to be freely available from our website. From next year, we will also be offering multidisciplinary one-day courses on intrapartum monitoring which will lead to an assessment and a certificate of competence.

4. **Neonatal deaths - prematurity:** Earlier this year, we alerted all neonatal units of our interim analysis of CESDI Project 27/28, which found that many deaths at these early gestations occur after high amounts of fluid administration for 'volume expansion'. WMPI has worked with the regional Neonatal Standards Group to encourage the adoption of guidelines to limit volume expansion. We are pleased to report that over the last six months, the number of neonatal units which have written guidelines on the use of volume expansion in the treatment of hypotension has risen from 6 of 16, to 15 of 16 units (38% to 94%)

5. **Denominator data:** Following a previous, successful pilot on the use of a 'minimum maternity dataset', the Institute has developed software which is ready for installation in interested maternity units. This project could be run for the modest cost of 60 k per year for the whole region. The collection of routine data would facilitate local and regional audit, and help in understanding social and ethnic causes and trends in perinatal mortality in the West Midlands. The Regional Levies Executive Board is supportive of this project but has so far been unable to fund it.