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INTRODUCTION

The last annual report of the Queensland Maternal and Perinatal Quality Council (QMPQC) was published in 2005 and it reported on 2002 and 2003 data. The Council, and before it the Queensland Council on Obstetric and Paediatric Morbidity and Mortality (QCOPMM), had functioned since 1995 to, primarily, review maternal and perinatal deaths (and paediatric deaths until the commencement of the Queensland Paediatric Quality Council) and there have been review of deaths from 1988 to 2003 by the QMPQC and QCOPMM.

With the introduction of the Health Quality & Complaints Commission (HQCC) in July 2006, and subsequent Queensland Health restructures, the Quality Councils ceased to function whilst their purposes and functionality were reviewed. The Councils remained gazetted to Queensland Health.

The Queensland Maternal and Perinatal Quality Council was reconvened in 2009 with the support of the Statewide Maternal and Neonatal Clinical Network (SMNCN), the Health Quality and Complaints Commission (HQCC), Private Hospitals Association of Queensland inc (PHAQ), and the Maternity Unit, Primary, Community and Extended Care Branch, Queensland Health (the Maternity Unit hosts the Secretariat). Membership and Terms of Reference were formally approved by the Queensland Health Patient Safety and Quality Executive Committee (PSQEC) in October 2009.

The purpose of the Queensland Maternal and Perinatal Quality Council is to:

• Collect and analyse clinical information regarding maternal and perinatal mortality and morbidity in Queensland to identify statewide and facility-specific trends.

• Make recommendations to the Minister for Health on standards and quality indicators of maternal and perinatal clinical care to enable health providers in Queensland to improve safety and quality

• Assist with the adoption of such standards in both public and private sectors.

The Council functions under the authority of the Health Services Act 1991, Division 2 Quality Assurance, to:

• Provide advice to the Minister via the triennial report and on a needs basis,

• Provide advice to the Patient Safety and Quality Executive Committee (PSQEC) via an annual report and on a needs basis, and

• Function collaboratively with the Statewide Maternal and Perinatal Clinical Network (SMNCN) and a Private Hospitals Maternity Liaison Group (supported by PHAQ).

The Council has prepared a work plan for 2010, with priority being given to review of:

• Maternal deaths,

• Perinatal deaths,

• Congenital anomalies,

• Severe maternal morbidity and risk factors,

• Implementation of statewide clinical guidelines, and

• Development of working relationships with other state and national bodies with similar agendas.

As these functions will take some time to complete, with catch up from 2004 onwards, Council decided to review statewide data from 1988 to 2007 to provide a snapshot of the position so far, providing a basis upon which to move forward. This report relates to that decision.

Professor Michael Humphrey
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