Maternity Services Addendum 2025 – Final Draft

Business Planning Framework

The Methodology for Nursing and Midwifery Workload Management

Maternity Services Addendum 2025 – Final Draft
Business Planning Framework: The Methodology for Nursing and Midwifery Workload Management. 6th Edition 2021

Published by the State of Queensland (Queensland Health), January 2025

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Introduction

The *Business Planning Framework: The Methodology for nursing and midwifery workload management 6th Edition 2021* (BPF) is the industrially mandated tool to support business planning for the purpose of managing nursing and midwifery resources and workloads in public sector health facilities. The principles of the tool apply to all remote, rural, regional and metropolitan nursing and midwifery services in Queensland Health. The Maternity Services Addendum (2018) was developed to recognise the unique challenges for midwives and nurses working in maternity services. We acknowledge the contribution of the original authors of the foundational document for this updated resource.

A consultative review of the Maternity Services Addendum (2018) was required to reflect updated resources and compliance with legislative and policy changes since 2018. This revised Maternity Services Addendum (2025) was created by a statewide maternity service review group incorporating membership from each Hospital and Health Services (HHS), Queensland Nurses and Midwives Union (QNMU) and the Department of Health (DoH). Changes to the addendum include support to embed the *Queensland Birth Strategy 2024–2030: A guide for clinicians*.

Throughout the addendum the terms newborn, neonate and baby are used interchangeably. The term woman is used throughout, however the document acknowledges that individualised sensitive maternity care is required by all persons accessing care.

This addendum will assist midwifery and nursing staff within maternity services to:

- determine and manage the unique circumstances within their service that require profession-specific considerations when applying the current Business Planning Framework and methodology
- provide examples of development of maternity specific service aims
- articulate updated productive (direct and indirect) midwifery and nursing activity within their maternity services
- articulate the current and emerging demand considerations for midwifery and nursing hours
- provide updated planning tables identifying productive and non-productive hours relevant to maternity services
- identify and describe client and service complexity, activity and performance measures to improve consistency in the application of the BPF in maternity services
- articulate the clinical care workload required for newborn babies
- articulate specific model of care requirements to direct resource allocation
- incorporate changes to evaluate maternity services workforce planning from a First Nations' perspective
- support system changes to implement the *Queensland Birth Strategy 2024–2030: A guide for clinicians*.

The format of the addendum aligns with BPF methodology and prompts are provided to assist service profile planning within the maternity context. These prompts are not designed to be an exhaustive list, rather a supplement and guide to encourage critical appraisal of service through a strategic midwifery lens.

Module 1. Guide for the Development of a Maternity Service Profile

There are several common midwifery and nursing workload management and workforce planning challenges within maternity services. The following issues are recognised nationwide as critical areas of concern:

- articulating maternity services in remote, rural and metropolitan settings
- validating indirect midwifery and nursing hours
- applying standard business planning definitions to maternity services
- accessing standardised maternity data collections and reporting systems
- articulating the hours required to support the diverse models of care within maternity services
- articulating the midwifery and nursing hours required for clinical care of the newborn.

The aim of maternity services is to achieve the safe provision of care for mother and baby, as close as possible to home [1]. However, some women and their babies may need to travel outside their local community to access necessary care. A woman and her baby's health require ongoing evaluation at each of the following stages of care:

- at booking
- during pregnancy
- during labour and birth
- during the postnatal period [2].

For some models of care this can extend to the first 2000 days [3].

The *Clinical Services Capability Framework* (CSCF) outlines minimum service requirements, workforce requirements, risk considerations, and support services to ensure safe and appropriately supported maternity clinical service delivery. There are a broad range of CSCF service activity types from level 1 to level 6 in maternity settings. To deliver the CSCF criteria for maternity services, consideration must be given to support:

- a sustainable midwifery workforce in remote, rural and regional locations to enable women to have clinically and culturally safe provision of care as close as possible to home
- allocated funding and established full-time equivalent (FTE) backfill requirements for planned leave, training and professional development entitlements to ensure sufficient workforce inclusive of all models of care.

The delivery of safe maternity services is also affected by the availability of additional services including:

- child health services
- immunisation
- hearing screening facilities and assessment
- perinatal mental health
- child safety services
- support from travel officers or coordinators
- medical imaging

- Lactation Consultants
- Diabetes Educators
- Allied Health Practitioners
- General Practitioners (GP) / General Practitioner Obstetrics (GPO) / General Practitioner Anaesthetics (GPA)
- Aboriginal and Torres Strait Islander Health Workers
- Aboriginal and Torres Strait Islander Practitioners
- Indigenous Liaison Officers
- Queensland Ambulance Services.

Identifying the Aim

The delivery of safe and responsive maternity care within the HHS strategic plan should be articulated within this section of the BPF.

For example

- To provide safe, sustainable, relational-based, woman-centred care, that is culturally safe and accessible to all.

Developing Objectives

Consumer Examples

- Business Case for Change (BCFC) commenced by 30 June to implement Publicly Funded Home Birth (PFHB) within 30 minutes travel catchment of facility.

- At commencement of the next financial year, a midwife-led antenatal clinic will commence on Saturdays.

Staff Examples

- 85% staff completion rate of the Kimberley Mums Mood Scale (KMMS) online learning and Clinical Yarning educational modules by end of calendar year.

- 50% reduction in excess leave balance is demonstrated in payroll reporting by end of calendar year.

Organisation Examples

- All staff have capacity to attend monthly clinical supervision sessions within 12 months.

- A net reduction of 4.0FTE premium labour usage by increased establishment and recruitment to 3.0FTE permanent midwifery positions by end of financial year.
- A Workplace Instruction for Management of Medical / Surgical Outliers in Maternity Inpatient units is published by the end of this financial year.

Describing the Service

The section broadly describes maternity services.

Location of the Service

Prompts include:

- geography
- travel by boat / car / aircraft required to reach services
- hub and spoke model
- service co-location
- community based services.

Type of Service/ Planned Service

Prompts include:

- declining birth rate
- CSCF change and if staffing uplift is required
- how and where services are delivered, for example, Publicly Funded Home Birth (PFHB)
- establishment of a community-based clinic.

Model of Care

The Maternity Care Classification System (MaCCS) is the national data system used to identify the 11 major model categories for maternity services with standardised definitions and nomenclature.

Within Queensland Public Maternity Services, the predominant models of care are:

- public hospital maternity care
- public hospital high risk maternity care
- shared care
- combined care
- midwifery group practice (MGP) caseload care
- remote area midwifery care
- private midwifery practice
- private obstetric (specialist) care.

Annual review and update of the models of care should be undertaken to ensure the MaCCS database accurately reflects models of care available within the maternity service. Models of care should also be described within the service profile.

Definitions and descriptors of maternity models of care are available in Appendix 1.
Further prompts for consideration include:

- Do the models meet community expectations?
- The established FTE for MGP could consider booking numbers as well as birth numbers to account for work caring for women who are transferred prior to birth or during labour (this is particularly important in rural models) [4]
- Services may include “mixed ward” type patients. Differentiating the maternity workload is imperative for service delivery.
- How does the model of care affect service delivery? For example, gynaecology clients presenting to Maternity Assessment units.
- What is the woman’s journey through the model?
- For GP shared care, does the out-of-pocket expense result in an increase in service expectation for antenatal clinics?
- Do MGP midwives function within the Service Agreement, or are they expected to also attend ‘rostered’ shifts to cover core services?
- Is there opportunity to explore contemporary models of care and flexible working arrangements?
- Is there a model of care for endorsed midwives to work at top of scope?

Access

This section describes the capability and accessibility of the service as per the CSCF.

Prompts include

- Are services co-located or remote?
- Are home visits standard care delivery?
- Are antenatal appointments available during non-standard hours to meet the woman’s preference?
- Are Aboriginal and Torres Strait Islander Health Care workers available?
- Is the model of care culturally safe and equitable in meeting the community’s needs?
- Are GP appointments readily available?
- Can prams enter all facilities?
- Does public transport connect services?
- Does the service offer transport to connect services?
- Are there service gaps? For example, do women have access to water immersion for labour and birth?
- Are women able to access their preferred model of care?
- Are the allocated caseload numbers appropriate to level of complexity? For example, complex social populations, culturally and linguistically diverse, and vulnerable communities.
- Is there consideration for women who are not Medicare eligible?

Environmental Analysis

External environmental analysis

It is important for the service to examine the impact or potential factors that external and internal environmental factors may have on services provided to ensure that the service profile maximises opportunities and mitigates potential risks.

Policy/ Legal

Describe the impact or potential impact of health policy and legislation on service delivery. Services should consider how changes to policy and legislative documents influence service delivery.

Prompts

- *Australian College of Midwives Guidelines for Consultation and Referral* - this can be used to guide clinical case conference.
- *National Maternity Action Plan for the Introduction of Community Midwifery Services in Urban & Regional Australia* - how does the service follow this?
- *Maternity & Neonatal Clinical Guidelines* – what impact do these guidelines have on workforce planning and workloads?
- *Growing Deadly Families Aboriginal and Torres Strait Islander Maternity Services Strategy 2019-2025* –Is there an opportunity to improve care?
- *National Immunisation Program* - how do updates effect workload?
- *Extended Practice Authority - Midwives* – how does the service use this in practice?
- *Nursing and Midwifery Board of Australia Decision-Making Framework* - are these embedded in practice?
- *Nursing and Midwifery Board of Australia Standards for Practice* - are these followed?
- *Queensland Birth Strategy 2024–2030: A guide for clinicians* - have all staff attended training? Is there a demonstrated change in practice and culture?
- *Termination of pregnancy* – does this impact on workloads? Is there a dedicated service and model of care?
- *Queensland Women and Girls Health Strategy* - Has this been considered by the service?
- *Human Rights Act 2019 (Queensland)* – How does the service build a culture that respects and promotes human rights?
- *Health Workforce Strategy for Queensland to 2032* - Does this support workforce planning for your service?
- *HEALTHQ32: A vision for Queensland's health system* - Do your service aims align with this vision?

Economic Factors

Describe the interface between funding / economic sources and health care providers that may impact the maternity services provided and the nursing and midwifery resources that are required.

Prompts

- Is the service Block Funded or does it have Activity Based Funding, i.e. Weighted Activity Units (WAU)?
- Is the service eligible for Council of Australian Governments (COAG) s19(2) Exemptions Initiative available to improve access to primary care in rural and remote areas [5]?
- Is private midwifery care available?
- Is an alternate private option for care available for the community?
- Does the current economic climate influence maternity service delivery, for example, does the rising cost of living, fuel costs, or inflation impact on ability to access care?
- Are the local MGP midwives required to provide postnatal care to women birthing elsewhere, or in private facilities?

Social Factors

Describe the population demographics, cultures, and community expectations that influence maternity service delivery and resources required.

Prompts

- What are the demographics of clients accessing services?
- How does the community demographic access your service including those who are culturally and linguistically diverse (CALD), marginalised, for example lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA+), have socioeconomic disadvantage, disability, are neuro diverse or have low health literacy?
- How does your service engage with vulnerable consumers?
- What is the level of health literacy for your service?
- Describe the level of codesign, partnership and engagement with First Nations community organisations
- Describe the level of consumer and community engagement.
- How do social factors influence workforce distribution, aging workforce profile, attrition, and turnover?
- Is the proportion of international graduates, university, and vocational, education and training (VET) sector enrolment rates, or other clinical profession maldistribution, affecting service delivery?
- What is the level of health literacy for your service?

Technology

Describe the external technology factors that could influence health care delivery.

Prompts

- Are midwives and nurses supported to embrace the continuous introduction and change with emerging technology?
- Does the service contribute to the external development of information technological applications (apps) for maternity care, including research opportunities?

- Is integration of all technology systems available within the service?
- Is remote access, for example, virtual private network (VPN), available for midwives to work remotely?
- Does the cost of data prevent access for midwives?
- Is a reliable internet connection and mobile telephone coverage available across all areas of the service including when providing care at home?
- Can the service access satellite telephones for remote service delivery?

Environment

Describe the impact of ecological and environment aspects on service delivery.

Prompts

- Describe seasonal trends evidenced in data activity, for example, the highest birth numbers per month are September / October, or the lowest booking numbers occur in May due to harvest / agriculture demands for rural residents.
- Describe extreme weather events that influence service delivery in your area, for example, during cyclone season an area is prone to flooding and storm surge resulting in decreased ability to provide home visiting. This also results in consumers having difficulty accessing facilities.

Research Evidenced Based Practice

Describe how research and evidenced-based activities influence activity with the service or change service delivery.

Prompts

- How will research findings be implemented within the service?
- How will research be conducted in a way that is appropriate and co-designed with Aboriginal and Torres Strait Islander people?
- Are there specific roles allocated to research or quality improvement?
- Consider how temporary funding relating to research positions are reflected within service planning
- Do external partnerships exist to support research activities?

Internal environmental analysis

Physical Structure

Physical infrastructure strongly influences care delivery and options available for maternity care. Ageing building infrastructure and building design impacts workflow efficiency, occupational health and safety, and security of staff.

Prompts

- Describe the numbers of birth suites, birth centres, inpatient beds and cots within the service.
- Does infrastructure support contemporary maternity care, for example water immersion in labour and waterbirth?

- Are there adequate clinical spaces available for client assessment?
- What is the demand, availability, and access to QFleet Vehicles?
- Does infrastructure support family-focused care, for example access to single rooms to support partners and private, sensitive bereavement care?
- Does the environment support the physiological needs of the woman in labour?
- Is the environment of the maternity service a private, safe, and culturally appropriate space?

Organisational Governance

Describe the operational structure of the service.

Prompts

- Describe the clinical governance systems and structures in the environment. For example, morbidity and mortality meetings, case reviews, clinical risk system management and response.
- What consumer partnership systems and structures are in place?
- Describe the accountability framework for the organisation.
- Describe alignment to local strategic and operational plans.
- Is the site external to another facility?
- Is a 'hub and spoke' model in place supporting smaller services?
- Is midwifery leadership remote across geographic locations?
- Is midwifery present in organisational leadership?
- Who are the operational and professional leads?
- Are First Nations maternity services operating under the correct clinical lead with cultural leads in the First Nations division?
- Does the organisation consider the effects of cultural load on Aboriginal and Torres Strait Islander employees?
- What are the governance processes for cultural awareness and cultural competency?
- How does the unit ensure industrial award and best practice rostering guidelines?
- What educational activities are in place to maintain contemporary midwifery skills?
- Describe services, governance, and alignment to *National Safety and Quality Health Service Standards* (NSQHS)
- Does the service prioritise protected time for staff access to clinical supervision?

Information Technology

Describe the management of clinical information technology (IT) systems.

Prompts

- What is the accessibility to clinical informatics support?
- What is the accessibility to IT hardware?

- Describe the interconnectivity of the systems.
- How proficient are midwives in using the systems?
- Do all services providing care access necessary data? For example, GP interface and access to the iCOPE digital platform.
- What is the quality and integrity of data produced?
- How visible is the data, for example, dashboards and SharePoint?
- Is transfer of information secure and meets the requirement for patient confidentiality within the *Privacy Act 1988*?
- What IT platform is used within MGP to communicate clinical needs?
- Does the IT platform meet the requirements of the Privacy Act and patient confidentiality?
- Is there education and implementation of new technology? For example, transition to the Integrated Electronic Medical Record (ieMR) and ongoing software and technical changes.
- How does telehealth impact the service? For example, equipment set-up, preparation of the woman and family, consultation assistance.
- Does the service utilise electronic rostering and payroll management systems?

Table 1: Information Systems

*Refers to systems available for Service Profile preparation.

Information system	Description	Utility
AGFA	Radiology reporting system	Medical records
Auscare / Auslab	Pathology	Accessing pathology results
Baby Coming You Ready (BCYR)	BCYR is a digital platform that has 'cracked the code' to overcome communication barriers between Aboriginal women and their health care provider during pregnancy and after baby arrives Baby Coming You Ready? - Supporting Aboriginal and Torres Strait Islander parents-to-be and new parents	Supports the social and emotional wellbeing of Aboriginal and Torres Strait Islander parents to be, and new parents
Best Practice	Best Practice (Bp) is the primary healthcare electronic medical record (EMR)	Medical records
C-Gov	Documentation management portal	Credentialing process
Decision Support System (DSS Panorama)*	Provides summary data reports displaying aggregate expenditure, budgets, variances and balances for cost centres and account codes for services. Reports are available for agency use, overtime, leave / absenteeism, position occupancy Provides performance dashboards including budget and human resource measurements DSS Homepage (health.qld.gov.au)	Workforce expenditure performance
Dragon	Ambient listening transcription in medical records.	Medical records

Information system	Description	Utility
Electronic Patient Journey board	Used in some facilities to manage patient flow also known as KYRA, Q-Manager, Patient Flow Manager (PFM)	Patient flow discharge planning
Electronic Theatre Booking	Used for Booking perioperative services	Patient flow
Enterprise Discharge Summary (EDS)	The EDS application uses information from a number of existing Queensland Health specialist systems to create a legible, consistent, electronic discharge summary. It allows the summary to be delivered electronically to general practices in a secure, timely and standardised format Enterprise Discharge Summary (EDS) and The Viewer - Home (health.qld.gov.au)	Client trends Client complexity Client outcomes performance Discharge summaries
Enterprise scheduling system (ESS)	Upgraded outpatient scheduling module used with electronic medical records, also known as Electronic Scheduling Management (ESM)	Appointment scheduling
ERIC – Hybrid electronic medical record management system	Used in some health services as partial electronic medical record to access historical medical information	Access to clinical information
Fluency for Flex (FFT)	Self-service, self-managed document creation tool for outpatient clinicians to create (type / copy and paste from ieMR), review, edit and approve (eSign) a letter for distribution	Medical records
Hospital Based Corporate Information System (HBCIS)*	Queensland Health's enterprise patient administration system, capturing and managing both admitted and non-admitted patient, clinical, administrative, and financial data This module provides functionality to place prospective patients on a waiting list, book expected admission dates for those patients, and maintain prospective patient details until they are admitted HBCIS online help - eHealth Queensland	Activity workforce Services performance Client demographics Referral / waitlist Financial reporting Waitlist management bookings
iCope	Digital screening platform that facilitates efficient, effective screening for risk factors and symptoms in the perinatal period iCOPE Digital Screening - COPE	Service delivery
iMED	An online network for reviewing radiology images	Radiology access
Integrated electronic medical record (ieMR) / Electronic medical Record (EMR)	Electronic source for various aspects of health care, including documentation; implemented across Queensland in different stages ranging from scanned solution to full digital hospital	Clinical access to patient information
iPharmacy	Pharmacy management system	Medication management
ISIS	Interpreter services information system	Interpreter services
K2 Guardian / Fetal Link	Fetal surveillance monitoring interpretation software	Clinical care
Kiteworks	Secure transfer service for transferring and receiving information to and from external parties	Information transfer

Information system	Description	Utility
Measurement Analysis Reporting System (MARS)*	Collect audit data electronically using existing forms, e.g. National Safety and Quality Health Service Standards audit tools. Data can be exported to Excel for analysis. Display results in dashboards (where available) as soon as data has been entered	Benchmarking data
McKesson Capacity Planner (West Moreton, Townsville, and Metro South)*	An online tool used to forecast patient demand and allocate staffing resources	Workload allocation capacity management
Medicare online	Used for checking eligibility for services	Medicare eligibility Check Medicare numbers
Monthly Activity Collection (MAC)*	Collects aggregate (or summary level) data on 'admitted' and 'non- admitted' patient activity from public acute hospital facilities, public residential psychiatric hospitals and public nursing homes / hostels / independent living units and multipurpose health services each month. Data is reported on Queensland Health's internet and internet sites 2024-2025 MAC Data Collection Guidelines and Business Rules	Activity provider type Client type Service type Performance Financial reporting
MyHR	Complete HR system where staff can access their payroll, personal information, leave balances and lodging of HR forms e.g. Leave form. Managers have access to their establishment and rostering practices, plus HR reports and electronic leave approval	Workforce management
Office 365*	Email and personal appointment management	Email and meeting management
Online Learning Platforms	Queensland Health's online learning management systems (LMS) used for delivery of online education, training and competency management. e.g. iLearn, Learning On-Line (LOL), Talent Management System (TMS), BIRCH, CQ learnt, and My Learn MSHLearn	Training completion and reporting
Operating Room Information Management System (ORMIS) / SurgiNET)	Operating Rooms data and patient information system	Minutes in operating theatre / recovery Provides intraoperative notes and post-operation management plans
Picture Archive and Communication system (PACS)	Medical imaging technology which provides economical storage and convenient access to images from multiple modalities	Access to scans and medical imaging
Perinatal Data Online (PNO)*	System to enter key perinatal data on a monthly basis which feeds into statewide maternity reporting	Models of care Clinical data / benchmarking Baby Friendly Health Initiative (BFHI) data / acuity / activity / clinical indicators

Information system	Description	Utility
Provider Digital Access (PRODA)	An online identity verification and authentication system which enables you to securely access government online services and make application for prescriber and provider numbers	Access to online services
Q Refer / e-Blueslips / Smart Referrals	To enable referral to services	Activity / acuity / access
QHERS	Queensland health electronic reporting system. Queensland Health employees can access a number of custom-made statistical reports, also referred to as IBIS	Statistical reporting
Q Manager / Q flow	Outpatient appointment management system / automated arrival system	Waiting room times length of appointment
Queensland Hospital Admitted Patient Data Collection (QHAPDC)*	The QHAPDC is the morbidity collection for all patients who have been admitted and separated from a hospital in Queensland. The information collected is used to manage, plan, research, and fund facilities at a local, State, and national level Queensland Hospital Admitted Patient Data Collection (QHAPDC) Manual, 2024-2025, Version 1.0	Activity Client complexity / Client trends Performance client outcomes Funding
RADNET / RIPS	Radiology system aligned to iEMR which allows viewing of radiology report and diagnostic medical images	Radiology reporting
RiskMan*	RiskMan is a single state-wide integrated information system to collect, integrate, manage, and report clinical incidents, workplace incidents, consumer feedback and risk.	Clinical incident system
Regional Information via Electronic Records (RIVeR)	Practice Management software	Patient flow / Service delivery
SPR*	Service performance and reporting	Statistical reporting
SWMIS	Maternity information system for electronic recording of patient encounters throughout pregnancy, also used for bed management	Encounters during pregnancy
The Viewer	Web-based application that displays consolidated clinical information sourced from a number of existing Queensland Health enterprise clinical and administrative systems	Access to clinical information
TIMS	Telstra integrated messaging system	Messaging services
TrendCare*	Information system for staff allocation, patient acuity data and staffing level requirements	Acuity Patient escorts N/MHPPD Non-nursing duties / verify indirect hours Workload allocation Efficiency reports
Integrated Workforce Management (iWFM)	Electronic rostering solution	Rostering and payroll

Information system	Description	Utility
Web-based messaging systems	Communication	Communication
WorkMapp*/ Anaplan (for MNHHS)	Electronic Business Planning Framework system. Software to enable development of service profile including roster construct / hours and FTE	Workforce planning
Electronic Workload Concern Form (eWCF)*	The electronic system for workload issues identified by nurses and midwives in Queensland Health	Workforce planning Service evaluation

Performance

Analysis of the previous performance of the service is necessary to plan for the upcoming financial year.

Consumer Performance

Consumer Activity

Describe the amount, trends and type of activity delivered to consumers:

- describe any trends seen in activity
- demonstrate equity of access to continuity of care within the service
- capture actual occasions of service across all models of care
- describe seasonal peaks and troughs
- provide comparative summary to previous BPF periods
- detail number of funded beds
- detail number of cots
- forecast anticipated demand for services – for example access to Public Funded Home Birth (PFHB).

Consumer Complexity

EXAMPLE OF HOW TO PRESENT CONSUMER COMPLEXITY FOR A MATERNITY SERVICE

Top 10 drg historical trends for the service (by separations)			
RANK	2018/19	2019/20	2020/21
1	P68D NEONATE, ADMWT >=2500G W/	P68D NEONATE, ADMWT >=250G W/	P68D NEONATE, ADMWT >=250G W/
2	O66B ANTENATAL AND OTHER OBSTE	O60B VAGINAL DELIVERY, INTERME	O60B VAGINAL DELIVERY, INTERME
3	O60B VAGINAL DELIVERY, INTERME	O66B ANTENATAL AND OTHER OBSTE	O66B ANTENATAL AND OTHER OBSTE
4	O66A ANTENATAL AND OTHER OBSTE	O66A ANTENATAL AND OTHER OBSTE	O66A ANTENATAL AND OTHER OBSTE
5	O60C VAGINAL DELIVERY, MINOR C	O60C VAGINAL DELIVERY, MINOR C	O60C VAGINAL DELIVERY, MINOR C
6	O60A VAGINAL DELIVERY, MAJOR C	O60A VAGINAL DELIVERY, MAJOR C	O60A VAGINAL DELIVERY, MAJOR C
7	O01B CAESAREAN DELIVERY, INTER	O01B CAESAREAN DELIVERY, INTER	O01B CAESAREAN DELIVERY, INTER
8	P68C NEONATE, ADMWT >=2500G W/	O10C CAESAREAN DELIVERY, MINOR	O05Z NEONATE, ADMWT >=250G W/
9	O05Z NEONATE, ADMWT >=250G W/	P68C NEONATE, ADMWT >=250G W/	P68C NEONATE, ADMWT >=250G W/
10	O01C CAESAREAN DELIVERY, MINOR	O05Z NEONATE, ADMWT >=250G W/	O10C CAESAREAN DELIVERY, MINOR

Note in the above example the greatest activity seen for the service is that of the newborn baby within maternity services.

Alternatively

- What percentage of clients have a normal physiological birth?
- Describe how low complexity is demonstrated within the service.
- How do you capture your consumer complexity in terms of needs outside of maternal outcome?

Newborn Babies

Consideration of the clinical care requirements of newborns within maternity services should be described within the service profile. This patient type refers to the newborn within a mother / baby unit including birth suite / centre, operating theatre, or postnatal ward. The workload describes direct clinical care delivered to the baby near the mother whenever possible. This patient type *excludes* qualified babies admitted to Special care Nursery or Neonatal Unit.

This workload can include:

- complete care requirements for newborns post-maternal cesarean section
- establishment and assessment of feeding
- recognition of increased monitoring to be compliant with statewide guidelines
- jaundice requiring treatment and management
- low birth weight baby observations, prevention / management of hypothermia
- assisted birth observations including head circumference measurement, and management of irritability
- provision of supervision and direct observation during skin-to-skin contact
- babies requiring neonatal abstinence scores and subsequent management
- management of unborn child high risk alerts and supervision of baby under the care of the Department of Families, Seniors, Disability Services and Child Safety
- stabilisation of the newborn and management of transfers
- management of Retrieval Services Queensland (RSQ) / neonatal RSQ consultations
- essential safety checks
- immunisation and completion of data entry.

Metrics for Measurement

As well newborn babies (i.e. those not admitted to Special Care Unit (SCU) or Neonatal Intensive Care Unit (NICU) are a new category of recognised patient type, accurate data sources may be difficult to capture this workload.

Example metrics may include:

- occupied cot days / fractional cot days
- length of stay
- number of healthy hearing tests / number of missed screens
- number of Newborn Bloodspot Screening Test (NBST) number requiring follow up i.e. missed / insufficient sample / repeat.

Safety and Quality – Consumer Safety and Quality Information

Describe the performance outcomes achieved by the service in relation to the agreed safety and quality framework. Maternity services should consider which indicators are appropriate for the service provided.

The most frequently reported nurse sensitive indicators are hospital acquired infection, mortality, failure to rescue, patient falls, pressure ulcers, medication error, length of stay, patient satisfaction and nurse satisfaction [7].

A review of the indicators and descriptive analysis within the service profile could provide justification for workforce planning or service delivery changes.

For example:

- an increasing length of stay compared with other similar services may prompt an initiative to increase midwifery led discharge
- “Measure What Matters” feedback may provide support to improve First Nations models of care and service redesign.

Midwifery Sensitive Indicators (MSIs) are not currently available in Queensland. The development of MSIs could provide valuable performance measurement data.

Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) provide invaluable performance measurement information. At the time of publication midwifery specific PREMs and PROMs are being trialled in Queensland maternity services.

The *International Consortium for Health Outcomes Measurement* (ICHOM) aims to promote the collection and reporting of common data for patients with identified health conditions. The ICHOM Pregnancy and Childbirth core outcome set includes patient-reported information collected through validated PREMs and PROMs at five time-points: booking visit, 34-weeks antenatal (34/40), birth (within 3-days), 6-weeks (6/52) and 6-months (24/52) after birth [8]. Consideration is given to the following measures:

- health-related quality of life
- pelvic pain and dysfunction
- breastfeeding confidence and success
- postnatal depression
- mother-infant attachment
- confidence in mother role
- satisfaction with care
- shared decision making
- birth experience.

Maternity services should consider the inclusion of this data set to inform service evaluation and workforce planning.

Further information is included in Appendix 3.

Example Consumer Performance Measures

In the absence of standardised metrics and measures, example measures could include:

- National Maternity Core Indicators [8]
- women's experience measures
- health screening processes and outcomes
- family violence screening / missed family violence screenings
- clinical incident reviews
- readmission rates of neonate less than 28 days
- maternal readmission rate
- hand hygiene compliance
- number of births attended by primary / named midwife
- Obstetric Anal Sphincter Injuries (OASI) rates
- number of women receiving midwifery continuity of carer
- exclusive breast feeding at discharge.

Further activity measures are provided in Appendix 2.

Staff Performance

Staffing Profile

Describe the organisational structure for the service. Individual services describe and determine the primary roles and functions, responsibilities, and accountability within the service to meet notational and legislated workforce requirements.

Prompts

- Define the retirement risk for midwives within the service.
- Detail clinical placement opportunities, for example, undergraduate midwifery students to have clinical placements in continuity models.
- Graduates are fundamental in succession planning. Adequate education infrastructure must accompany growing graduate numbers.
- Opportunities to work to full scope of practice in midwifery continuity of care models vary and has implications on attracting and retaining the midwifery workforce.
- Generational workforce changes require agile workforce planning solutions to provide sustainability and meet generational work styles and preferences.
- Dedicated clinical supervision time to support long term health and wellbeing of clinical staff is a priority.
- Detail explicit midwifery leadership and separate models of care within the service, for example, ‘Options Clinics’, Bereavement Clinical Midwife Consultant (CMC), Navigators, Lactation CMC and the impact on service delivery.

- First Nations services, models of care and leadership.
- Is there sufficient FTE to ensure sick leave, fatigue leave or annual leave cover in all models of care?

Professional Development, Training and Education

Statewide expectations and training matrixes vary. There is no standard approach. Considerations for the training requirements and professional accountability expectations for midwives include (but are not limited to):

- Practical Obstetric Multiprofessional Training (PROMPT)
- water immersion for labour and birth
- neonatal resuscitation
- *Fetal Surveillance Education Program*
- breast feeding education for Baby-Friendly Hospital Initiative (BFHI)
- safe infant sleeping
- domestic violence awareness and screening
- child safety education
- assessment of the newborn
- Kimberley Mum's Mood Scale (KMMS) and clinical yarning
- Safer Baby Bundle / Stronger Bubba Born (SBB)
- *Improving Perinatal Mortality Review & Outcomes Via Education (IMPROVE) workshop*
- Newborn bloodspot screening
- Queensland Birth Strategy education
- New technology / IT systems and ongoing training for system updates
- Strength with Immersion (SWiM) programmes.

Consideration for workforce planning should also include:

- access to clinically based facilitators / coaches to assist with graduate midwives and new staff for sufficient clinical and professional support
- travel time to attend training that is not provided locally
- rostered portfolio days
- staff engagement in succession planning
- availability of midwife student positions or placements
- permanent employment of midwifery graduates to consolidate practice
- opportunities for midwives in remote, rural and regional birthing services to develop and maintain skills at a higher CSCF service.

Consider backfill needs to enable the release of staff to attend training. This is attainable when a suitable casual pool is established within the service. In speciality areas, such as maternity services, it is an option to establish productive FTE to enable establishment and recruitment of a suitable workforce to ensure access to staff training and maintenance of direct clinical care.

Metrics for evaluation

Consideration for evaluation includes:

- mandatory training completion rate and role required training
- postgraduate and undergraduate student midwife completion rates, opportunities to enhance clinical placements, Post-Graduate Student Midwife (PGSM) / midwifery students / clinical support requirements
- staff completing SWiM programme
- staff completing lactation qualification and facility compliance with BFHI
- BFHI requirements being met, for example, midwives providing multidisciplinary training to all professional groups across hospitals and other campuses
- staff completing endorsement and adoption of models of care that enable midwives to work to full scope
- percentage of staff receiving continuing education accelerated advancement (qualifications) entitlement.

Staff Performance Measures

Consider:

- vacancy rates
- staff turnover
- overtime utilisation
- casual / agency hours
- workload concerns
- absenteeism
- extra part-time hours for midwives
- overtime / Time off in Lieu (TOIL) payout for MGP
- retention of graduates and students in permanent workforce
- temporary to permanent conversions
- overleave balances.

Organisation

Organisational Culture

"Everything for the profession of midwifery is led by the midwifery profession" [9].

Consideration needs to be given to individual leadership and management requirements, and the support systems available within the maternity service. These may impact the level of demand placed on productive midwifery and nursing hours.

Challenges in maternity services to meet such demands may include.

- multiple management responsibilities across numerous models of care (e.g. single Maternity Unit Manager overseeing antenatal clinics, birth suite, and caseload midwives)
- inequitable allocation across services to onsite dedicated leadership and midwifery management
- absence of experienced, dedicated, clinical, and operational midwifery leadership onsite
- geographically removed (hub and spoke style) leadership
- continued preference for midwifery leadership versus nursing leadership
- availability of backfill to support leadership development and mentoring
- facilitating a peer support network for Maternity Unit Managers (MUM), CMCs and Nurse / Midwife Educators across the state
- time for collaboration with multidisciplinary leaders
- articulating the role of team leaders and shift supervisors, and allocating appropriate midwifery and nursing hours
- advocating and negotiating for evidenced based practice where woman-centred care is poorly understood
- access to clinical supervision
- understanding of contemporary midwifery models of care [10].

Service Agreement and Key Performance Indicators

Safety and Quality

Quality improvement and safety activities within maternity services are primarily governed by legislation and organisational policy. The productive midwifery and nursing hours of the health service are influenced by quality and safety processes.

Key Quality and Safety Components

Key quality and safety components which may impact productive midwifery and nursing hours include:

- Quality Improvement (QI) activities, such as The Safer Baby Bundle and Preterm Birth Collaborative, directly affect workloads for midwives during the project(s) and afterwards. Any change in clinical service delivery should be included in subsequent BPF planning cycles
- QI activities can also improve work practices and workflow and any positive change should also be reflected in BPF provisions This distribution of direct and indirect hours should be contextualised for the service based on variables such as type of service delivered, model(s) of care, population dynamics, staff competency requirements, and location of unit or program where delivered
- the need to undertake audits, data collection, completion of reports, Variable Life Adjustment Display (VLADs)
- completion of CSCF self-assessment
- measuring Key Performance Indicators (KPIs) for maternity services
- measuring and responding to consumer feedback
- Ministerial / Office of the Health Ombudsman (OHO) responses

- application of the NSQHS standards
- participation in accreditation review processes
- introduction of changes to evidence-based guidelines
- policy, procedure, and clinical guideline development and review
- management of Ryan's Rule escalation process
- implementation of root cause analysis (RCA), human error and patient safety outcomes
- clinical incident and 'near miss' reporting, including participating in clinical reviews
- response to workplace aggression or threatened / actual physical violence, for example, child safety removal with police presence.
- undertaking Morbidity and Mortality Review processes.

Financial Outcomes

Describe the financial outcomes for the service. Describe any significant budget labour variances, for example:

- vacant MGP 4.0FTE - Agency usage negative budget variance
- Clinical Facilitator – resignation - position vacant 3 months pending recruitment - positive variance
- improved clinical documentation resulting in improved clinical coding and resource allocation
- increased activity from non-maternity patients requiring external agency and casual usage, and no allocation of funding/ Weighted Activity Units (WAU)

Comparative analysis and benchmarking

Benchmarking can prove challenging in the maternity setting as standardised data sets do not exist. All health services are required to contribute to Queensland Health Perinatal Data Collection (PDC) and some health services also contribute to data sets such as Women's Health Australasia (WHA) and / or Health Round Table. These data sets can generate useful information for comparative analysis with National Core Maternity Indicators [11] or be benchmarked against Australian Institute of Health and Welfare's Australia's Mothers and Babies [12]. Identifying areas of high performance or opportunities for improvement can be useful to strengthen the service profile development and provide future service aims.

Process Benchmarking

Process benchmarking observes, investigates, and compares service processes with other organisations to determine those processes that are best practice. For example:

- number of clients receiving at least five (5) antenatal visits
- Percentage of women receiving continuity of carer.

Financial Benchmarking

Financial benchmarking compares the service's financial outcomes in relation to achieving value for money. For example:

- the introduction of midwifery led discharge at six (6) hours, reducing length of stay and occupied bed

days by x%, saving $x per annum.

- FTE of premium labour usage demonstrated in previous financial reporting period.

Performance Benchmarking

Performance benchmarking investigates and compares service outcomes against predetermined national targets to evaluate the provision of safe care. For example:

- comparison of service outcomes to Queensland's Perinatal Data Collection (PDC) or Women's Health Australasia (WHA) data sets.

Strategic Benchmarking

Strategic benchmarking observes and compares organisational strategic direction and achievements with internal and external services. For example:

- access to First Nations' model of care in partnership with Aboriginal Community Controlled Health Organisations (ACCHOS), delivering 100% community-based care.

Functional Benchmarking

Functional benchmarking observes and compares the functions of the organisation and how these impact on service delivery. For example:

- benchmarking recruitment processes such as time to hire, cost per hire, and employee retention rates against industry standards.

Forecasting.

Reviewing activity data, occupancy, and occasions of service can assist with forecasting trends for future maternity service activity. Forecasting also implies predicting what positions, skills, and capabilities will be required for future success, considering available resources.

Prompts

- Describe the number of women requesting access to specific models and are unable to access their model of choice.
- A reduction in demand for service should also be described, for example, increased transfers of care due to increased care requirements outside of service capability.
- Is there a general population increase or decrease due to environment or geography?
- Has there been an increase in out-of-hours presentations requiring a cardiotocograph (CTG) due to decreased fetal movement?

Further example activity measures are provided in Appendix 2.

SWOT Analysis (Strengths Weaknesses Opportunity Threats)

This section provides the opportunity to articulate a high-level summary of the content of Module 1. A SWOT analysis provides the narrative and justification to support innovative models of care.

An example SWOT is available in the Business Planning Framework 6th Edition page 27.

Module 1 Summary

SUMMARY

When developing Module 1, the following has been considered to establish the service demand:

The agreed service profile is considered the primary source of information regarding required nursing and midwifery resource allocation.

Historical service-based analysis of nursing and midwifery resources used in previous periods.

Analysis of consumer activity/acuity trends and other environmental factors that have impacted nursing and midwifery services.

Forecasting of future consumer activity/acuity trends and other environmental factors that will impact nursing and midwifery services.

Comparative analysis and benchmarking the service with similar nursing and midwifery services and/or applying the relevant evidence.

Consultation with nursing and midwifery staff delivering the service.

Module 2: Guide to completing Resource Allocation

Establishing Nursing and Midwifery hours to meet Service Requirement's Supply and Demand

Step 1

Productive midwifery and nursing hours include direct and indirect clinical hours. Calculating the number of productive hours required for a maternity service is the first step in managing midwifery and nursing workloads and establishing the total operating midwifery and nursing budget, specifically identifying the FTE.

Productive hours should be determined with reference to the factors which have been identified and described in Module 1 of the service profile:

- legislated minimum midwife-to-patient ratio
- historical payroll / finance Information
- minimum safe staffing models of care
- service / organisational benchmarking
- patient / consumer dependency information
- forecasting
- professional judgement
- consultation with nurses and midwives delivering the service.

Direct Hours

Describe hours spent on activities that are directly related to clinical care.

Indirect Hours

Indirect hours should be identified and negotiated at the individual service level to ensure the context of practice, models of care, and unique circumstances are considered.

Table 2: Examples of key productive and non-productive midwifery and nursing hours

Activity	Productive		Non-Productive	Examples
	Direct	Indirect		
Service delivery				
Operational and strategic planning		x		Business and strategic planning
Scheduling clinics		x		Triaging referrals, scheduling management of ongoing care
Room management		x		Room allocation, managing overruns, directing clinic activity
Ward / unit bed management		x		Patient flow management, bed allocation and re-allocation for safety
Inventory and stock control		x		Sterile stock management and ordering
Chart coordination and management		x		Preparing charts, managing woman and baby information, test results and follow up appointments

Activity	Productive		Non-Productive	Examples
	Direct	Indirect		
Woman and baby assessments in inpatient setting (emergency presentation of the pregnant woman)	x			Monitoring, and woman and fetal assessment
Case management	x			Caseload midwives, antenatal clinics, high risk pregnancies, multidisciplinary team collaboration
Referral management		x		Triaging and prioritising diagnostics testing
Woman and family education	x			Birthing and parenting education / classes, antenatal classes, Baby Friendly Hospital Initiative
Breastfeeding care	x			Information, assessment, education, support for woman and baby
Clinic delivery (hospital and community)	x			Antenatal clinics, lactation consult clinics, antenatal classes, iron infusions, community midwifery service visits e.g. Early Days home visits, immunisation, and vaccination clinics
Procedures	x			Includes set ups, procedures and clean ups, specific observations for woman and baby (relevant to Maternity and Neonatal Statewide Clinical Guidelines)
Telehealth services	x	x		Clinic delivery and follow-ups, management of equipment
Birth suite	x			1:1 midwife to woman when in active labour and two hours postpartum, skin to skin contact,
Induction of labour	x			Education and consent
Caesarean section	x			Booking for procedure, transfer to theatre, skin to skin contact
Clinical care of neonate	x			Assessment and monitoring of baby e.g. regular blood glucose level as per clinical guidelines
Care planning and evaluation	x			Woman related arrangements such as patient travel, translators, and complex diagnostics
Discharge planning	x			Discharge from birth suite, baby discharge from special care nursery, midwifery-led discharge
Clinical documentation	x			Medical records, woman related charts (handheld pregnancy record)
Clinical handover/ handoff	x			Woman and baby transfers, shift changes, shared care arrangements
Woman and baby escorts	x			Intra and inter-hospital
Clinical team leading		x		Staff coordination
Psychosocial support for family	x			Support for family through emergency procedures, pregnancy loss, fetal demise
Follow ups	x			Post birth, supporting women who chose to options outside of recommended guidelines

Activity	Productive		Non-Productive	Examples
	Direct	Indirect		
Service data collection and analysis		x		Perinatal Data Collection
Staff management				
Rostering		x		Daily, weekly, and monthly rostering of staff
Leave management		x		Annual, sick, fatigue and study / research leave
Skill mix management and allocation		x		Team leader duties
Human resource management		x		Pay enquires, staff movement forms
Recruitment and retention		x		Advertising, interviewing, developing retention strategies
Data collectingand analysis		x		Labour expenditure, leave management, monthly reports
Staff travel		x		Organising travel, undertaking travel
Staff development				
Clinical supervision		x		Professional support / learning, reflective practice
Clinical facilitation		x		Education of and mentoring undergraduate, postgraduates, and new starters
Mandatory / specialty training			x	Neonatal life support, child safety, ergonomics, PROMPT, refer to Education and service capacity development
Staff education (in clinical area)		x		Internal and external (e.g. service partners attending training sessions)
In-service training		x		Ward / unit / service-based education and training sessions
Professional development/portfolios		x		Clinical portfolios
Performance appraisal and development (PAD) / Performance Development Plan (PDP)		x		Participation in PAD / PDP process and Performance Improvement Process (PIP)
Succession planning		x		Workplace shadowing, professional development
Staff meetings		x		Unit / workplace based
Evidence-based practice		x		Research activities/ service-based projects
Policy development and enforcement				
Committee participation		x		Internal and external committees
Designated legislation, policy, or quality programs		x		Quality audits / safety checks, morbidity, and mortality meetings
Health service planning		x		Service capacity building and workforce planning

Activity	Productive		Non-Productive	Examples
	Direct	Indirect		
Clinical governance practices		x		Policy review and development
Ministerial responses		x		Woman and family complaints, service delivery issues
Information management				
Balanced scorecard		x		Evaluation tools
Data analysis		x		Service improvements, Perinatal Data Collection review
Business planning and management		x		Service profile development
Electronic medical records	x			Woman and baby related information, real-time data entry including observations, clinical notes, scheduling
Other				
Travel		x		Travel associated with service delivery e.g. clinics at multiple sites
Equipment and infrastructure maintenance		x		Car servicing, building repairs, equipment repairs
Procurement and plantmaintenance		x		Obtaining quotes, ordering of equipment forservice delivery
Risk assessment for community services		x		Ensuring safety for staff completing home visits

Please note: Education and training programs provided within the clinical service / program / facility are considered productive indirect hours. Clinical hours associated with mandatory training and professional development leave for education purposes is allocated within non-productive hours.

Step 2

Determine the skill mix / category of the nursing / midwifery hours required for the service.

This may include CMCs, MUMs, Registered Midwives (RM) / Registered Nurses (RN), RN Midwifery Students, Undergraduate Students in Midwifery (USIM), Clinical Midwives, and Clinical Facilitators rostered across the service to meet activity requirements.

Step 3

Convert productive nursing / midwifery hours into FTE equivalents (refer to workforce planning digital solution, WorkMapp).

Step 4

Calculate non-productive nursing and midwifery hours in accordance with nursing and midwifery award entitlements.

Step 5

Convert non-productive nursing and midwifery hours into FTE equivalents.

Step 6

Add productive and non-productive FTE equivalents together and convert into financial resources in partnership with the business team.

This step provides the ability to negotiate the requirements of the FTE from a financial perspective. Interest-based problem solving is essential to ensure the allocated FTE supplied meets the demands of the service demonstrated and evidenced within the profile document.

Step 7

Allocate nursing and midwifery hours to meet service requirements.

Appendix 4 provides a Maternity Service WorkMapp case study demonstrating the application of resource allocation utilising WorkMapp for a Mother Baby Unit and Midwifery Group Practice.

Summary

In summary, all workforce plans for maternity services should be undertaken with midwifery expertise in planning. This should be demonstrated by appropriate sign–off and approval demonstrating midwifery professional judgement in the execution of resource allocation.

Module 3: Guide to Evaluation of Performance

A key component of the BPF cycle is evaluating performance. Performance evaluation will assist in assessing results against the planning as well as form key information when commencing the next annual cycle, this is depicted in Figure 1.

Figure 1.

Measuring and Monitoring Performance

Maternity Services should regularly review the service plan to determine if service aims and objectives described in Module 1 are achieved.

Performance Measures

The application of performance measures will improve the collection and analysis of data to support the delivery of services.

Effectiveness Measures

Service Effectiveness Measures reflect the actual outcomes achieved for consumers, staff, and the organisation. Evaluation compliance and success in relation to the service aims and objectives are described in module 1.

Maternity specific examples include:

- 5 or more antenatal visit rates
- smoking cessation rates.

Cost Effectiveness Measures relate to the the operating budget and the actual outcome including:

- labour performance indicators
- increased midwifery led discharge resulting in a reduction of length of stay and associated savings
- implementation of midwife-to-patient ratios resulting in a percentage reduction of admissions to Neonatal Unit (NNU)
- DSS Budget Spend Summary Dashboard.

Efficiency Measures

Efficiency measures reflect the actual capability of resources allocated to meet the service's operational targets.

Technical Efficiency requires services to be delivered at the lowest possible cost.

Maternity specific examples include:

- percentage of women cared for within a MGP service
- percentage of spontaneous vaginal births (SVB)
- percentage of women accessing non-pharmacological pain relief.

Allocative Efficiency requires the delivery of health services that are most valued by customers and are provided within the given set of resources. This is perhaps the most influential, informative performance measure for maternity services to consider**.**

Maternity specific examples include:

- maternity specific PREMS and PROMS, which provide the best data set to measure service quality from the consumer perspective.

Dynamic Efficiency entails consumers being offered existing services and new services at a higher quality and / or lower cost.

Maternity specific examples include:

- increased access to MGP continuity of care
- introduction of PFHB
- reduction in length of stay
- implementation of self-referral pathways
- increased telehealth access to specialists to reduce travel and rural transfers
- implementation of endorsed midwife models of care.

Activity Measures reflect the volume of work undertaken by the service including the number of services, number of consumers, and any other associated activity.

Maternity specific examples include:

- number of booking visits compared to number of births
- occupied cot days / occupied bed days.

Process Measures reflect how the service is delivered. Process measures can be substituted for effectiveness measures if it is practical, or uneconomical, to measure the service or its outcomes any other way. A general example is the number of patients assessed in time for specialist outpatient clinics.

Maternity specific examples could include:

- early trimester screening attended within an appropriate timeframe
- time from referral to first appointment.

Input Measures reflect the human and consumable resources required to deliver a service as an absolute figure or percentage.

Examples include:

- sick leave utilisation and FTE usage
- budgeted FTE and premium labour costs.

Quality Measures reflect the service's ability to provide high quality safe services. Quality indicators work in conjunction with other measures to ascertain service effectiveness.

Maternity specific examples include:

- maternity specific indicators
- PREMS / PROMS
- audit compliance.

Equity Measures reflect how well a service is meeting the needs of groups within the community. These measures are used to demonstrated variances in outcomes between groups.

Maternity specific examples include:

- comparison of First Nation-centred model of care outcomes compared to mainstream care
- percentage of First Nations workforce compared to First Nations client population demographics

- ‘Did not wait’ times for all clients.

Performance Dashboard

A versatile reporting measure to monitor performance is a dashboard. This enables maternity services to identify trends and performance over time.

A DSS dashboard example:

BPF Nursing and Midwifery Labour Performance Indicators

Hierarchy / Structure / Design
• QH Alt 7 • Cost centre code • Calendar year date range • QH FTE • Monthly data • 12-month trend / summary
Nursing and Midwifery Labour Indicators
• Overtime percentage (OT) • Casual percentage • External percentage • Sick Leave percentage • Productive FTE • Maternity leave FTE • Recreation leave FTE • Unfilled substantive establishment FTE
Financial Performance
• Labour budget ($) • Labour actual ($) • Labour variance $

Balancing Supply and Demand

The BPF provides a formal methodology for aligning workplace demand with the supply of nursing and midwifery professionals. This alignment ultimately supports safe and appropriate staffing levels and workplace provisions. Utilisation of the BPF enables clinical leaders to advocate for resources in a defined and considered way.

By applying the BPF methodology in consultation with the BPF Maternity Service Addendum, managers can effectively utilise BPF principles to ensure resources for maternity services align with actual service provision. This resource acknowledges that professional judgment is a valid criterion for determining safe staffing levels. Nurses and midwives should consider their professional responsibilities and expertise to prioritise tasks, ensuring that safe nursing and midwifery care is maintained.

In situations where there is an imbalance in staffing, the principles of interest-based problem solving should be applied when utilising the workload management escalation process. Nurses and midwives should have strategies for managing their workloads to ensure the safety of both consumers and staff.

These strategies include a ‘low-priority activity list’ and workload concern escalation process. It is important to note that low-priority activity lists may vary from service to service, depending on the specific context of practice. The workload concern escalation process aids staff and managers in effectively addressing and resolving workload concerns that arise, ensuring that safe, high-quality health care services are delivered.

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National Health Reform Performance and Accountability Framework

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Nursing and Midwifery Board of Australia Decision-making Framework http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Frameworks.aspx

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Workplace Relations Act 1996 https://www.legislation.gov.au/Details/C2006C00104

Appendix 1 | Maternity Models of Care Definitions

Public hospital maternity care

- Antenatal care is provided in hospital outpatient clinics (either onsite or outreach) by midwives and / or doctors. Care may also be provided by a multidisciplinary team.
- This is the broadest model category and includes a range of models of care from those led by midwives that target low risk women to those led by obstetricians that target women with obstetric risk factors such as diabetes.
- Intrapartum and postnatal care is provided in hospital by midwives and doctors in collaboration.
- Postnatal care may continue in the home or community by hospital midwives.

Shared care

- Antenatal care is provided by a community maternity service provider (doctor and / or midwife) in collaboration with hospital medical and / or midwifery staff under an established agreement.
- Can occur both in the community and in hospital outpatient clinics.
- Usually includes an agreed schedule of antenatal care between two providers.
- Intrapartum and early postnatal care usually takes place in the hospital, by hospital midwives and doctors, often in conjunction with the community doctor or midwife (particularly in rural settings).

Midwifery group practice caseload care

- Antenatal, intrapartum and postnatal care is provided within a publicly funded caseload model by a known primary midwife with secondary backup midwives providing cover and assistance, in collaboration with doctors, in the event of identified risk factors.
- Antenatal care and postnatal care are usually provided in the hospital, community or home with intrapartum care in a hospital, birth centre or home.
- This category provides continuity of carer across the whole maternity period.

Private obstetrician specialist care

- Antenatal care is provided by a private specialist obstetrician.
- Intrapartum care is provided in either a private or public hospital by the private specialist obstetrician in collaboration with hospital midwives.
- Postnatal care is usually provided in the hospital by the private specialist obstetrician and hospital midwives and care by midwives may continue in the home, hotel or hostel.
- Most models in this category provide continuity of carer across the whole maternity period.

Public hospital high risk maternity care

- Antenatal care is provided to women with medical high risk / complex pregnancies by public hospital maternity care providers (i.e. specialist obstetricians and / or maternal-fetal medicine sub-specialists in collaboration with midwives).
- Intrapartum and postnatal care is provided by hospital doctors and midwives.
- Postnatal care may continue in the home or community by hospital midwives.
- This category is *not* used for obstetric-led clinics (models of care) such as those designed for women with diabetes or with risk factors such as high Body Mass Index (BMI). Models requiring obstetric input, but not multi-disciplinary specialised care, are classified as *public hospital maternity care*.

General practitioner (GP) obstetrician care

- Antenatal care is provided by a GP obstetrician.
- Intrapartum care is provided in either a private or public hospital by the GP obstetrician in collaboration with the hospital midwives.
- Postnatal care is usually provided in the hospital by the GP obstetrician and hospital midwives.

Remote area maternity care

- Antenatal and postnatal care is provided in remote communities by a remote area midwife (or nurse) or group of midwives, sometimes in collaboration with a remote area nurse and / or doctor.
- Antenatal care may also be provided via telehealth or fly-in-fly-out clinicians in an outreach setting.
- Intrapartum and early postnatal care is provided in a regional or metropolitan hospital, often involving temporary relocation prior to labour, by hospital midwives and doctors.

Combined care

- Antenatal care is provided by a private maternity service provider (doctor and / or midwife) in the community.
- Intrapartum and early postnatal care is provided in a public hospital, by hospital midwives and doctors.
- Postnatal care may continue in the home or community by hospital midwives.
- Usually exists without a shared care agreement, so there is no agreed schedule of visits between providers and the private provider does not provide any care in hospital.

Private midwifery care

- Antenatal, intrapartum and postnatal care is provided by a privately practicing midwife or group of midwives in collaboration with doctors in the event of identified risk factors.
- Antenatal, intrapartum and postnatal care could be provided in a range of locations including the home.
- This category is used when the designated maternity carer is a privately practicing midwife but is not used if the model of care is shared care between a private midwife and a hospital as part of a formal arrangement.

Team midwifery care

- Antenatal, intrapartum and postnatal care is provided by a small team of rostered midwives in collaboration with doctors in the event of identified risk factors.
- Intrapartum care is usually provided in the hospital or birth centre.
- Postnatal care may continue in the home or community by the team midwives.

Private obstetrician and privately practising midwife joint care

- Antenatal, intrapartum and postnatal care is provided by a privately practising obstetrician and midwife from the same collaborative private practice.
- Intrapartum care is usually provided in either a private or public hospital by the privately practising midwife and / or private obstetrician in collaboration with hospital midwifery staff.
- Postnatal care is provided in hospital and may continue in the home.

Reference

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Appendix 2 | Example Activity Measures

These measures may form a data set to enable visibility of activity, complexity or acuity that may inform an analysis or trended activity to guide workforce planning. It is not an exhaustive list that must be completed.

Clinics – Antenatal, Specialist

- number of appointments (new and review)
- out of hours clinics and number of Occasions of Service (OOS)
- number of no shows / missed opportunity for care (previously known as FTA)
- number and location of community clinics
- number of pathology specimens collected
- number of procedures attended
- number of assessments, e.g. cardiotocography (CTG) attended
- number of women requiring patient travel support
- number of presentations to Obstetric Review Clinic
- categorisation of referrals
- number of specialist telehealth appointments (requiring midwife support)
- number of clinical results requiring further management
- number of charts requiring retrieval and filing
- number of non-urgent non-ambulance bookings
- number of clinic appointments requiring chaperoning
- percentage (%) of clients with Gestational Diabetes Mellitus (GDM) in pregnancy
- number of women in GP share care
- number of women who have care from a known midwife across whole continuum
- number of women in team midwifery
- early pregnancy and bereavement support
- termination access and service delivery

Birth Suite

- number of births (including multiples)
- number of spontaneous births
- number of inductions of labour
- caesarean section rate, elective versus emergency
- number of Post-Partum Hemorrhages (PPH)
- number of births at home / number of transfers to hospital (PFHB)
- number of vaginal births after caesarean (VBAC)
- number of water births
- number of after-hours OOS for BFHI
- proportion of women and babies with skin-to-skin contact - BFHI
- number of women where breastfeeding is initiated in birth suite
- number of high-risk births
- number of telephone calls managed in birth suite
- number of women admitted to High Dependency Unit (HDU) or Intensive Care Unit (ICU) after birthing
- number of transfers of women requiring complex care and higher-level transfer
- number of birth registrations completed
- number of episodes of education delivered in birth suite
- number of women requiring interpreter
- number of multidisciplinary students i.e., Queensland Ambulance Service, medical, physio, midwifery, nursing, rural generalists

Birth Centre

- number of home visits
- number of telephone consultations
- number of episodes of parent education
- early labour home assessment

Ward

- number of inductions of labour
- number of terminations of pregnancy
- number of still births
- number of complex care, e.g. Gestational Diabetes Mellitus (GDM)
- number of vaginal births after caesarean (VBAC)
- number of post-partum hemorrhages (PPH)
- hours per patient day
- occupied bed days, fractional bed days
- number of separations
- number of telephone consultations
- number of outlier patients cared for in maternity ward
- number of ward review OOS
- number of episodes of parent education

Unqualified Neonatal Inpatient (Babies)

- blood glucose monitoring and subsequent management of hypoglycemia
- gestation on admission historically admitted to a SCN or neonatal unit now remaining in mother baby ward (including adjusted age)
- utilisation and management of Expressed Breast Milk (EBM)

Home Visiting

- distance / geographical location
- number of clients
- complexity of woman and baby
- number of risk assessments completed for staff safety
- age range of babies to whom home visits are provided, e.g. up to six weeks

Day Assessment Unit / Triage

- number of pathology specimens collected
- number of procedures attended
- number of assessments attended, e.g. CTG
- number of booked appointments
- number of unplanned appointments
- categorisation of referrals
- number of iron infusions administered
- number of telephone consultations
- length of stay
- number of non-maternity clients – separate clinic / activity for gynecology.

Appendix 3 | Pregnancy and Childbirth Flyer

ICHOM

Pregnancy & Childbirth

Conditions covered

Types: Pregnancy | Labor and delivery | Up to six months postpartum
Stages: Early | Middle | Late

Details

1 Tracked via the PROMIS-10
2 Evaluated with the PHQ-2, optional follow-up with the EPDS
3 Option to track via the BSES-SF
4 Tracked via the ICIQ-SF and Wexner, Wexner and the PROMIS SFFAC102
5 Tracked via the MIBs
6 Tracked via the BSS-R

For a complete overview of this Set, including definitions for each measure, time points for collection, and associated risk factors, visit http://www.ichom.org/medical-conditions/pregnancy-and-childbirth/

Reference

International Consortium for Health Outcome Measures, "Pregnancy & Childbirth Flyer," International Consortium for Health Outcome Measures, January 2022. [Online]. Available: http://www.ichom.org/medical-conditions/pregnancy-and-childbirth/ [Accessed 16 December 2024]

Appendix 4 | Case Study

For the purposes of demonstrating maternity specific resource allocation the following hypothetical WorkMapp plan examples are provided:

- CSCF Level 3 rural facility
- situated 300 kms by road to the closest CSCF Level 5 facility
- stable booking numbers per annum 300
- birth rate onsite 270 per annum
- 100% access to MGP
- caseload allocation up to 35 women allocated per FTE midwife per annum
- ten (10) funded beds
- five (5) funded cots.

Example 1 | Mother Baby Unit Plan

Queensland Government

Private Plan Report: 01 Jul. 2024 - 30 Jun. 2025

Plan Name: Service Profile: Mother Baby Unit

Private Plan ID
43957

Executive Summary

FTE & Loadings Summary

Roster FTE: 15.52 *Position Count: 4*		Standard (STP) FTE: 13.87			Base Budget (BBP) FTE: 16.69			Establish Recruit (ERP) FTE: 17.07		
Loading Name	**Award Value**	**Avg Weighting** *Applied Range*	**FTE**	**Impact**	**Avg Weighting** *Applied Range*	**FTE**	**Impact**	**Avg Weighting** *Applied Range*	**FTE**	**Impact**
Annual Leave *Across 3 positions*	11.5385 % of Time	-77.78% *-100% - 0%*	-1.55		77.78% *0% - 100%*	1.55		77.78% *0% - 100%*	1.55	
Annual Leave *Across 1 positions*	9.6154 % of Time	-100.00% *-100% - -100%*	-0.10		100.00% *100% - 100%*	0.10		0.00% *0% - 0%*	0.00	
External - Professional Development Leave *Across 1 positions*	1.1538 Days p/a	0.00% *0% - 0%*	0.00		0.00% *0% - 0%*	0.00		0.00% *0% - 0%*	0.00	
Mandatory Training - New & Existing Average *Across 4 positions*	2.6923 % of Time	0.00% *0% - 0%*	0.00		20.00% *0% - 29%*	0.10		0.00% *0% - 0%*	0.00	
Maternity Leave *Across 2 positions*	260 Days p/a	0.00% *0% - 0%*	0.00		21.67% *9% - 32%*	0.40		0.00% *0% - 0%*	0.00	
Professional Development Leave *Across 3 positions*	1.1538 % of Time	0.00% *0% - 0%*	0.00		87.50% *0% - 100%*	0.16		0.00% *0% - 0%*	0.00	
Sick Leave *Across 4 positions*	3.8462 % of Time	0.00% *0% - 0%*	0.00		70.00% *0% - 100%*	0.52		0.00% *0% - 0%*	0.00	
Total Loadings			**-1.65**	*-10.63%*		**2.83**	*18.22%*		**1.55**	*10.01%*
Total FTE (incl Loadings)			**13.87**			**16.69**			**17.07**	

Roster Analysis by hours per fortnight

Designation Type / Designation	Skill Mix	Total		Direct		Indirect	
		%	Hours	%	Hours	%	Hours
NURSE		**100%**	**1,179**	92%	1,088	8%	91

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Queensland Government

Private Plan Report: 01 Jul. 2024 - 30 Jun. 2025

Plan Name: Service Profile: Mother Baby Unit

Private Plan ID
43957

Roster Analysis by hours per fortnight

Designation Type / Designation	Skill Mix	Total		Direct		Indirect	
		%	Hours	%	Hours	%	Hours
NRG5		58%	687	98%	672	2%	15
NRG6		28%	336	100%	336	0%	0
NRG2		7%	80	100%	80	0%	0
NRG7		6%	76	0%	0	100%	76
Total		100%	1,179	92%	1,088	8%	91

Queensland Government

Private Plan Report: 01 Jul. 2024 - 30 Jun. 2025

Plan Name: Service Profile: Mother Baby Unit

Private Plan ID
43957

Service Planning Summary. Current values calculated as at 11 Dec. 2024. Projected values calculated as at 11 Dec. 2029

Service Metric

ID	Entity	Service	Metric Group Code	Metric Name	Code	Current Svc Days p/FN	Current Multiplier	Current Metric	Current Metric Bal p/Day	Proj Metric Bal p/Day
8896	Hospital & Health Service	All Service Types	BED	Overnight Bed	BPF24/25	14	100.00%	15.00	15.00	→ 15.00

ID	Employment Class	Target Hours			Allocated Hours		Target / Allocated variance hours	Available Roster FN Hours	Comments
		Hours per Metric (HPM)	Total Daily Hours	Total FN Hours	Roster FN Hours	Hours per Metric (HPM)			
913	NURSE	0.00	0.00	0.00	1,088.00	5.18	1,088.00	1,179.20	

Definitions

Current values calculated as at 11 Dec. 2024.

Allocated HPM calculation = [Allocated Roster FN Hours] divided by [current service days per FN] divided by [current metric balance per day].

Queensland Government

Private Plan Report: 01 Jul. 2024 - 30 Jun. 2025

Plan Name: Service Profile: Mother Baby Unit

Private Plan ID

43957

Ratio Analysis

Number of **Overnight Bed** (current metric balance per day: 15.00) per one (1) rostered Staff

	Mon 1	Tue 1	Wed 1	Thu 1	Fri 1	Sat 1	Sun 1	Mon 2	Tue 2	Wed 2	Thu 2	Fri 2	Sat 2	Sun 2
Early	4.29	4.29	4.29	4.29	4.29	5.00	5.00	4.29	4.29	4.29	4.29	4.29	5.00	5.00
Late	4.29	4.29	4.29	4.29	4.29	5.00	5.00	4.29	4.29	4.29	4.29	4.29	5.00	5.00
Night	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00	5.00

Pos #	Designation Type Code	Designation Code	Position Code	Position Description	Rostered Hours
3046228	NURSE	NRG5	NRG5	RM Maternity	672.00
3200703	NURSE	NRG2	NRG2	Undergraduate StudentNrsMidwifery	80.00
3046228	NURSE	NRG6	NRG6-1	CM Maternity	336.00

Definitions

Ratio values are calculated using the [current metric balance] (as at plan start date) divided by the [rostered staff] headcount value taken from roster records in the plan that meet the following criteria:
Criteria 1 - Roster record must be linked to a metric record via the target hours.
Criteria 2 - Roster record must be allocated to an AM, PM or ND shift.
Criteria 3 - Roster record must be allocated to a task with the 'include in ratio's' attribute activated.

Disclaimer - The metric and roster record values used to calculate ratio values are maintained and validated by system users within WorkMAPP. Ratio values in the above table are provided for information purposes only. The use of ratio values for additional analysis or compliance checking is the responsibility of the plan report user.

Queensland Government

Private Plan Report: 01 Jul. 2024 - 30 Jun. 2025

Plan Name: Service Profile: Mother Baby Unit

Private Plan ID
43957

Position Summary

Des. Type Code	Des. Code	Cost Centre	Pos Desc	Pos Number	Roster FTE	Standard FTE	Base FTE	Establish. FTE
NURSE	NRG5	Mother Baby Unit	RM Maternity	3046228	9.04	8.00	9.88	10.09
			Annual Leave			-1.04	1.04	1.04
			Award Value: 11.5385 Percent of Time. *Percent of award value applied*			*-100.00%*	*100.00%*	*100.00%*
			Mandatory Training - New & Existing Average			0.00	0.07	0.00
			Award Value: 2.6923 Percent of Time. *Percent of award value applied*			*0.00%*	*28.57%*	*0.00%*
			Maternity Leave			0.00	0.32	0.00
			Award Value: 260 Days Per Annum. *Percent of award value applied*			*0.00%*	*31.55%*	*0.00%*
			Professional Development Leave			0.00	0.10	0.00
			Award Value: 1.1538 Percent of Time. *Percent of award value applied*			*0.00%*	*100.00%*	*0.00%*
			Sick Leave			0.00	0.35	0.00
			Award Value: 3.8462 Percent of Time. *Percent of award value applied*			*0.00%*	*100.00%*	*0.00%*
NURSE	NRG2	Mother Baby Unit	Undergraduate StudentNrsMidwifery	3200703	1.05	1.05	1.05	1.05
			Annual Leave			0.00	0.00	0.00
			Award Value: 11.5385 Percent of Time. *Percent of award value applied*			*0.00%*	*0.00%*	*0.00%*
			External - Professional Development Leave			0.00	0.00	0.00
			Award Value: 1.1538 Days Per Annum. *Percent of award value applied*			*0.00%*	*0.00%*	*0.00%*
			Mandatory Training - New & Existing Average			0.00	0.00	0.00
			Award Value: 2.6923 Percent of Time. *Percent of award value applied*			*0.00%*	*0.00%*	*0.00%*
			Sick Leave			0.00	0.00	0.00
			Award Value: 3.8462 Percent of Time. *Percent of award value applied*			*0.00%*	*0.00%*	*0.00%*
NURSE	NRG7	Mother Baby Unit	MUM Maternity	3046228	1.00	0.90	1.00	1.00
			Annual Leave			-0.10	0.10	0.00
			Award Value: 9.6154 Percent of Time. *Percent of award value applied*			*-100.00%*	*100.00%*	*0.00%*

Queensland Government

Private Plan Report: 01 Jul. 2024 - 30 Jun. 2025

Plan Name: Service Profile: Mother Baby Unit

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Des. Type Code	Des. Code	Cost Centre	Pos Desc	Pos Number	Roster FTE	Standard FTE	Base FTE	Establish. FTE
			Mandatory Training - New & Existing Average			0.00	0.00	0.00
			Award Value: 2.6923 Percent of Time. *Percent of award value applied*			*0.00%*	*0.00%*	*0.00%*
			Professional Development Leave			0.00	0.00	0.00
			Award Value: 1.1538 Percent of Time. *Percent of award value applied*			*0.00%*	*0.00%*	*0.00%*
			Sick Leave			0.00	0.00	0.00
			Award Value: 3.8462 Percent of Time. *Percent of award value applied*			*0.00%*	*0.00%*	*0.00%*
NURSE	NRG6	Mother Baby Unit	CM Maternity	30462284	**4.42**	**3.91**	**4.76**	**4.93**
			Annual Leave			-0.51	0.51	0.51
			Award Value: 11.5385 Percent of Time. *Percent of award value applied*			*-100.00%*	*100.00%*	*100.00%*
			Mandatory Training - New & Existing Average			0.00	0.03	0.00
			Award Value: 2.6923 Percent of Time. *Percent of award value applied*			*0.00%*	*28.57%*	*0.00%*
			Maternity Leave			0.00	0.08	0.00
			Award Value: 260 Days Per Annum. *Percent of award value applied*			*0.00%*	*8.50%*	*0.00%*
			Professional Development Leave			0.00	0.05	0.00
			Award Value: 1.1538 Percent of Time. *Percent of award value applied*			*0.00%*	*100.00%*	*0.00%*
			Sick Leave			0.00	0.17	0.00
			Award Value: 3.8462 Percent of Time. *Percent of award value applied*			*0.00%*	*100.00%*	*0.00%*
				Total	15.52	13.87	16.69	17.07

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Plan Name: Service Profile: Mother Baby Unit

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Roster Details

Week 1

CC Code	Is Direct	Shift	Roster Code	Pos Code	Pos Number	Pos Description	Mon		Tue		Wed		Thu		Fri		Sat		Sun		Total
							Hrs	Sta	Hrs	Sta	Hrs	Sta	Hrs	Sta	Hrs	Sta	Hrs	Sta	Hrs	Sta	Hrs
	No	Early		NRG5	3046228	RM Maternity	7.6	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	7.6
	No	Early		NRG7	3046228	MUM Maternity	7.6	1.0	7.6	1.0	7.6	1.0	7.6	1.0	7.6	1.0	0.0	0.0	0.0	0.0	38.0
		Subtotal Shift: Early					15.2	2.0	7.6	1.0	7.6	1.0	7.6	1.0	7.6	1.0	0.0	0.0	0.0	0.0	45.6
	Subtotal Is Direct: No						15.2	2.0	7.6	1.0	7.6	1.0	7.6	1.0	7.6	1.0	0.0	0.0	0.0	0.0	45.6
	Yes	Early		NRG2	3200703	Undergraduate StudentNrsMidwifery	4.0	0.5	4.0	0.5	4.0	0.5	4.0	0.5	4.0	0.5	0.0	0.0	0.0	0.0	20.0
	Yes	Early		NRG5	3046228	RM Maternity	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	112.0
	Yes	Early		NRG6-1	3046228	CM Maternity	8.0	1.0	8.0	1.0	8.0	1.0	8.0	1.0	8.0	1.0	8.0	1.0	8.0	1.0	56.0
		Subtotal Shift: Early					28.0	3.5	28.0	3.5	28.0	3.5	28.0	3.5	28.0	3.5	24.0	3.0	24.0	3.0	188.0
	Yes	Late		NRG2	3200703	Undergraduate StudentNrsMidwifery	4.0	0.5	4.0	0.5	4.0	0.5	4.0	0.5	4.0	0.5	0.0	0.0	0.0	0.0	20.0
	Yes	Late		NRG5	3046228	RM Maternity	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	112.0
	Yes	Late		NRG6-1	3046228	CM Maternity	8.0	1.0	8.0	1.0	8.0	1.0	8.0	1.0	8.0	1.0	8.0	1.0	8.0	1.0	56.0
		Subtotal Shift: Late					28.0	3.5	28.0	3.5	28.0	3.5	28.0	3.5	28.0	3.5	24.0	3.0	24.0	3.0	188.0
	Yes	Night		NRG5	3046228	RM Maternity	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	112.0
	Yes	Night		NRG6-1	3046228	CM Maternity	8.0	1.0	8.0	1.0	8.0	1.0	8.0	1.0	8.0	1.0	8.0	1.0	8.0	1.0	56.0
		Subtotal Shift: Night					24.0	3.0	24.0	3.0	24.0	3.0	24.0	3.0	24.0	3.0	24.0	3.0	24.0	3.0	168.0
	Subtotal Is Direct: Yes						80.0	10.0	80.0	10.0	80.0	10.0	80.0	10.0	80.0	10.0	72.0	9.0	72.0	9.0	544.0
Week 1 Total							95.2	12.0	87.6	11.0	87.6	11.0	87.6	11.0	87.6	11.0	72.0	9.0	72.0	9.0	589.6

Queensland Government

Private Plan Report: 01 Jul. 2024 - 30 Jun. 2025

Plan Name: Service Profile: Mother Baby Unit

Private Plan ID
43957

Week 2

CC Code	Is Direct	Shift	Roster Code	Pos Code	Pos Number	Pos Description	Mon		Tue		Wed		Thu		Fri		Sat		Sun		Total
							Hrs	Sta	Hrs	Sta	Hrs	Sta	Hrs	Sta	Hrs	Sta	Hrs	Sta	Hrs	Sta	Hrs
2500401	No	Early		NRG5	3046228	RM Maternity	7.6	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	7.6
2500401	No	Early		NRG7	3046228	MUM Maternity	7.6	1.0	7.6	1.0	7.6	1.0	7.6	1.0	7.6	1.0	0.0	0.0	0.0	0.0	38.0
		Subtotal Shift: Early					15.2	2.0	7.6	1.0	7.6	1.0	7.6	1.0	7.6	1.0	0.0	0.0	0.0	0.0	45.6
	Subtotal Is Direct: No						15.2	2.0	7.6	1.0	7.6	1.0	7.6	1.0	7.6	1.0	0.0	0.0	0.0	0.0	45.6
2500323	Yes	Early		NRG2	3200703	Undergraduate StudentNrsMidwifery	4.0	0.5	4.0	0.5	4.0	0.5	4.0	0.5	4.0	0.5	0.0	0.0	0.0	0.0	20.0
2500401	Yes	Early		NRG5	3046228	RM Maternity	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	112.0
2500401	Yes	Early		NRG6-1	3046228	CM Maternity	8.0	1.0	8.0	1.0	8.0	1.0	8.0	1.0	8.0	1.0	8.0	1.0	8.0	1.0	56.0
		Subtotal Shift: Early					28.0	3.5	28.0	3.5	28.0	3.5	28.0	3.5	28.0	3.5	24.0	3.0	24.0	3.0	188.0
2500323	Yes	Late		NRG2	3200703	Undergraduate StudentNrsMidwifery	4.0	0.5	4.0	0.5	4.0	0.5	4.0	0.5	4.0	0.5	0.0	0.0	0.0	0.0	20.0
2500401	Yes	Late		NRG5	3046228	RM Maternity	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	112.0
2500401	Yes	Late		NRG6-1	3046228	CM Maternity	8.0	1.0	8.0	1.0	8.0	1.0	8.0	1.0	8.0	1.0	8.0	1.0	8.0	1.0	56.0
		Subtotal Shift: Late					28.0	3.5	28.0	3.5	28.0	3.5	28.0	3.5	28.0	3.5	24.0	3.0	24.0	3.0	188.0
2500401	Yes	Night		NRG5	3046228	RM Maternity	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	16.0	2.0	112.0
2500401	Yes	Night		NRG6-1	3046228	CM Maternity	8.0	1.0	8.0	1.0	8.0	1.0	8.0	1.0	8.0	1.0	8.0	1.0	8.0	1.0	56.0
		Subtotal Shift: Night					24.0	3.0	24.0	3.0	24.0	3.0	24.0	3.0	24.0	3.0	24.0	3.0	24.0	3.0	168.0
	Subtotal Is Direct: Yes						80.0	10.0	80.0	10.0	80.0	10.0	80.0	10.0	80.0	10.0	72.0	9.0	72.0	9.0	544.0
Week 2 Total							95.2	12.0	87.6	11.0	87.6	11.0	87.6	11.0	87.6	11.0	72.0	9.0	72.0	9.0	589.6
Grand Total							190.4	24.0	175.2	22.0	175.2	22.0	175.2	22.0	175.2	22.0	144.0	18.0	144.0	18.0	1,179.2

Annual Hours Formula

Annual nursing and midwifery productive hours = weekly nursing and midwifery productive hours x 52

For example: 589.60 weekly productive hours x 52 weeks = **30,659.20** total annual productive hours

Total Bed Days per Annum

For example: 10 beds + 5 cots = 15 beds / cots x 365 days / year = **5,475** total bed days

Nursing / Midwifery Hours per Patient day[1] (N/MHpPd) = total annual productive hours / total bed days per annum

For example, **30,659.20** total annual productive hours / **5,475** total bed days per annum = **5.59** (N/MHpPd)

Direct N/MHpPd is **5.18** Hours Per Metric (HPM) on WorkMapp.

The application of Midwifery / Nursing Hours per Patient Day (N/MHpPD) or Midwifery / Nursing Hours per Occasions of Service (N/MHpOOS), Midwifery / Nursing Hours per Unit of Activity (N/MHpUA) does not always provide an adequate representation of the full scope of activity or acuity demands upon the midwifery and nursing workforce in the maternity setting.

TrendCare Benchmark Ranges HPPD

Activity	Hours per Patient Day (HPPD)
Maternity Postnatal - Caesarean Section	3.90 - 6.82
Baby Post Natal	2.58 - 5.60
Maternity Postnatal Vaginal Birth	3.91 - 6.21
Labour - Small Hospital	7.21 - 13.53
Maternity Antenatal	3.46 - 5.27

Note: Deployment to Birth Suite to assist MGP midwife is required within the Model of Care.

[1] *TrendCare Projected Patient Type HPPD Benchmark Ranges 2024/2025. Trend Care Systems PTY LTD*

Example 2 | Midwifery Group Practice

Queensland Government

Private Plan Report: 01 Jul. 2024 - 30 Jun. 2025

Plan Name: Midwifery Group Practice

Private Plan ID
43958

Executive Summary

FTE & Loadings Summary

Roster FTE: 9.00 *Position Count: 3*		Standard (STP) FTE: 8.13			Base Budget (BBP) FTE: 9.42			Establish Recruit (ERP) FTE: 9.00		
Loading Name	**Award Value**	**Avg Weighting** *Applied Range*	**FTE**	**Impact**	**Avg Weighting** *Applied Range*	**FTE**	**Impact**	**Avg Weighting** *Applied Range*	**FTE**	**Impact**
Annual Leave *Across 3 positions*	9.6154 % of Time	-100.00% *-100% - -100%*	-0.87		100.00% *100% - 100%*	0.87		0.00% *0% - 0%*	0.00	
Mandatory Training - New & Existing Average *Across 3 positions*	2.6923 % of Time	0.00% *0% - 0%*	0.00		28.57% *29% - 29%*	0.07		0.00% *0% - 0%*	0.00	
Professional Development Leave *Across 3 positions*	1.1538 % of Time	0.00% *0% - 0%*	0.00		100.00% *100% - 100%*	0.10		0.00% *0% - 0%*	0.00	
Sick Leave *Across 3 positions*	3.8462 % of Time	0.00% *0% - 0%*	0.00		69.99% *70% - 70%*	0.24		0.00% *0% - 0%*	0.00	
Total Loadings			**-0.87**	*-9.62%*		**1.28**	*14.23%*		**0.00**	*0.00%*
Total FTE (incl Loadings)			**8.13**			**9.42**			**9.00**	

Roster Analysis by hours per fortnight

Designation Type / Designation	Skill Mix	Total		Direct		Indirect	
		%	Hours	%	Hours	%	Hours
NURSE		**100%**	**684**	100%	684	0%	0
NRG5		**56%**	**380**	100%	380	0%	0
NRG6		**44%**	**304**	100%	304	0%	0
Total		**100%**	**684**	**100%**	**684**	**0%**	**0**

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Queensland Government

Private Plan Report: 01 Jul. 2024 - 30 Jun. 2025

Plan Name: Service Profile: Midwifery Group Practice

Private Plan ID
43958

Service Planning Summary. Current values calculated as at 11 Dec. 2024. Projected values calculated as at 11 Dec. 2029

Service Metric										
ID	Entity	Service	Metric Group Code	Metric Name	Code	Current Svc Days p/FN	Current Multiplier	Current Metric	Current Metric Bal p/Day	Proj Metric Bal p/Day
8898	Hospital & Health Service	General Obstetrical Services	IN	Caseload Midwifery	BPF24/25	14	100.00%	1.00	1.00	→ 1.00

Definitions

Current values calculated as at 11 Dec. 2024.

Allocated HPM calculation = [Allocated Roster FN Hours] divided by [current service days per FN] divided by [current metric balance per day].

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Private Plan Report: 01 Jul. 2024 - 30 Jun. 2025

Plan Name: Service Profile: Midwifery Group Practice

Private Plan ID
43958

Position Summary

Des. Type Code	Des. Code	Cost Centre	Pos Desc	Pos Number	Roster FTE	Standard FTE	Base FTE	Establish. FTE
NURSE	NRG5	MIDWIFERY GROUP PRACTICE	RM CASELOAD MIDWIFE	3210222	**4.00**	**3.62**	**4.18**	**4.00**
				Annual Leave		-0.38	0.38	0.00
			Award Value: 9.6154 Percent of Time. *Percent of award value applied*			*-100.00%*	*100.00%*	*0.00%*
				Mandatory Training - New & Existing Average		0.00	0.03	0.00
			Award Value: 2.6923 Percent of Time. *Percent of award value applied*			*0.00%*	*28.57%*	*0.00%*
				Professional Development Leave		0.00	0.05	0.00
			Award Value: 1.1538 Percent of Time. *Percent of award value applied*			*0.00%*	*100.00%*	*0.00%*
				Sick Leave		0.00	0.11	0.00
			Award Value: 3.8462 Percent of Time. *Percent of award value applied*			*0.00%*	*69.99%*	*0.00%*
NURSE	NRG6	MIDWIFERY GROUP PRACTICE	CM Caseload Midwife	30481090	**4.00**	**3.62**	**4.18**	**4.00**
				Annual Leave		-0.38	0.38	0.00
			Award Value: 9.6154 Percent of Time. *Percent of award value applied*			*-100.00%*	*100.00%*	*0.00%*
				Mandatory Training - New & Existing Average		0.00	0.03	0.00
			Award Value: 2.6923 Percent of Time. *Percent of award value applied*			*0.00%*	*28.57%*	*0.00%*
				Professional Development Leave		0.00	0.05	0.00
			Award Value: 1.1538 Percent of Time. *Percent of award value applied*			*0.00%*	*100.00%*	*0.00%*
				Sick Leave		0.00	0.11	0.00
			Award Value: 3.8462 Percent of Time. *Percent of award value applied*			*0.00%*	*69.99%*	*0.00%*
NURSE	NRG5	MIDWIFERY GROUP PRACTICE	RM Graduate Caseload Midwife	32041325	**1.00**	**0.90**	**1.05**	**1.00**
				Annual Leave		-0.10	0.10	0.00
			Award Value: 9.6154 Percent of Time. *Percent of award value applied*			*-100.00%*	*100.00%*	*0.00%*
				Mandatory Training - New & Existing Average		0.00	0.01	0.00
			Award Value: 2.6923 Percent of Time. *Percent of award value applied*			*0.00%*	*28.57%*	*0.00%*

Queensland Government

Private Plan Report: 01 Jul. 2024 - 30 Jun. 2025

Plan Name: Service Profile: Midwifery Group Practice

Private Plan ID
43958

Des. Type Code	Des. Code	Cost Centre	Pos Desc	Pos Number	Roster FTE	Standard FTE	Base FTE	Establish. FTE
			Professional Development Leave			0.00	0.01	0.00
			Award Value: 1.1538 Percent of Time. *Percent of award value applied*			*0.00%*	*100.00%*	*0.00%*
			Sick Leave			0.00	0.03	0.00
			Award Value: 3.8462 Percent of Time. *Percent of award value applied*			*0.00%*	*69.99%*	*0.00%*
				Total	9.00	8.13	9.42	9.00

Queensland Government

Private Plan Report: 01 Jul. 2024 - 30 Jun. 2025

Plan Name: Service Profile: Midwifery Group Practice

Private Plan ID
43958

Roster Details

Week 1

CC Code	Is Direct	Shift	Roster Code	Pos Code	Pos Number	Pos Description	Mon		Tue		Wed		Thu		Fri		Sat		Sun		Total
							Hrs	Sta	Hrs	Sta	Hrs	Sta	Hrs	Sta	Hrs	Sta	Hrs	Sta	Hrs	Sta	Hrs
	Yes	Early		NRG5	3204132	RM Graduate Caseload Midwife	7.6	1.0	7.6	1.0	7.6	1.0	7.6	1.0	7.6	1.0	0.0	0.0	0.0	0.0	38.0
	Yes	Early		NRG5	3210222	RM Caseload Midwife	30.4	4.0	30.4	4.0	30.4	4.0	30.4	4.0	30.4	4.0	0.0	0.0	0.0	0.0	152.0
	Yes	Early		NRG6-1	3048109	CM Caseload Midwife	30.4	4.0	30.4	4.0	30.4	4.0	30.4	4.0	30.4	4.0	0.0	0.0	0.0	0.0	152.0
		Subtotal Shift: Early					68.4	9.0	68.4	9.0	68.4	9.0	68.4	9.0	68.4	9.0	0.0	0.0	0.0	0.0	342.0
	Subtotal Is Direct: Yes						68.4	9.0	68.4	9.0	68.4	9.0	68.4	9.0	68.4	9.0	0.0	0.0	0.0	0.0	342.0
Week 1 Total							68.4	9.0	68.4	9.0	68.4	9.0	68.4	9.0	68.4	9.0	0.0	0.0	0.0	0.0	342.0

Week 2

CC Code	Is Direct	Shift	Roster Code	Pos Code	Pos Number	Pos Description	Mon		Tue		Wed		Thu		Fri		Sat		Sun		Total
							Hrs	Sta	Hrs	Sta	Hrs	Sta	Hrs	Sta	Hrs	Sta	Hrs	Sta	Hrs	Sta	Hrs
	Yes	Early		NRG5	320413	RM Graduate Caseload Midwife	7.6	1.0	7.6	1.0	7.6	1.0	7.6	1.0	7.6	1.0	0.0	0.0	0.0	0.0	38.0
	Yes	Early		NRG5	321022	RM Caseload Midwife	30.4	4.0	30.4	4.0	30.4	4.0	30.4	4.0	30.4	4.0	0.0	0.0	0.0	0.0	152.0
	Yes	Early		NRG6-1	304810	CM Caseload Midwife	30.4	4.0	30.4	4.0	30.4	4.0	30.4	4.0	30.4	4.0	0.0	0.0	0.0	0.0	152.0
		Subtotal Shift: Early					68.4	9.0	68.4	9.0	68.4	9.0	68.4	9.0	68.4	9.0	0.0	0.0	0.0	0.0	342.0
	Subtotal Is Direct: Yes						68.4	9.0	68.4	9.0	68.4	9.0	68.4	9.0	68.4	9.0	0.0	0.0	0.0	0.0	342.0
Week 2 Total							68.4	9.0	68.4	9.0	68.4	9.0	68.4	9.0	68.4	9.0	0.0	0.0	0.0	0.0	342.0
Grand Total							136.8	18.0	136.8	18.0	136.8	18.0	136.8	18.0	136.8	18.0	0.0	0.0	0.0	0.0	684.0

Annual Hours Formula

Annual Nursing and Midwifery Productive Hours = Weekly nursing and Midwifery Productive Hours x 52

For example, 342 weekly hours x 52 weeks = **17,784** total annual productive hours

Caseload equivalent Midwifery hours per client

17,784 total annual productive hours / **300** women booked for the service = **59.28** hours per woman

Annual Hours per Annum per Midwife

38 hours x 52 weeks = **1,976** hours per annum per midwife, less 6 weeks annual leave,

i.e. 6 weeks x 38 hours = **228** hours.

Hours available = total hours less annual leave

1,976 hours per annum per midwife – **228** hours annual leave = **1,748** available hours per annum per midwife.

Midwifery Hours Allocation per Woman per Midwife

1,748 available hours per annum per midwife for **35** women = **49.90** hours per woman per midwife, i.e.

1,748 / 35 = 49.90 hours per woman per midwife.
Caseload allocation midwife-to-woman ratio is 1:35.

Considerations

- The WorkMapp roster pattern does not align with MGP ways of working and non-shift-based way of working.
- Services should document agreed local ways of working to establish how hours are allocated across the continuum of pregnancy care including antenatal, intrapartum, and postnatal care.
- Consideration should be given to the annual leave required, for example, for 9 FTE x 6 weeks annual leave = 45 weeks of annual leave for the year for the MGP.
- Consider MGP establishment to include leave backfill.
- Job classification restructure for Midwife to replace Nurse.
- Further refinement of WorkMapp is required to align with MGP ways of working.

Acknowledgements

Queensland Health acknowledges the authors, reviewers and editors of the Business Planning Framework: The Methodology for Nursing and Midwifery Workload Management 6th Edition 2021 and Business Planning Framework: A tool for Nursing and Midwifery Workload Management, Maternity Services Addendum 2018 from which this document is derived.

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