

Business Planning Framework:

a tool for nursing and midwifery
workload management

5th Edition 2016

Maternity Services Addendum 2018

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Introduction

The *Business Planning Framework: a tool for nursing and midwifery workload management* 5th Edition (BPF 5th Edition) 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 BPF 5th Edition apply to all remote, rural, regional and metropolitan nursing and midwifery services in Queensland Health. This addendum is designed to recognise the unique challenges for midwives and nurses working in maternity services and must be used in conjunction with the BPF 5th Edition.

The Maternity Services Addendum was developed to meet the commitment between Queensland Health (QH) and the Queensland Nurses and Midwives' Union (QNMU) under the provisions of the Nurses and Midwives (Queensland Health and Department of Education and Training) Certified Agreement (EB9) 2016. The agreement identified the need to further contextualise the BPF 5th Edition for a range of settings, including maternity services, to support compliance with the Nursing and Midwifery Workload Management Standard.

The Maternity Services Addendum was created by a statewide maternity service Specialty User Group in partnership with QNMU and the Department of Health.

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

- determine and manage the unique circumstances within their service that require special consideration when applying the principles of the BPF 5th Edition
- articulate productive (direct and indirect) midwifery and nursing activity within their service
- understand the current and emerging demand considerations for midwifery and nursing hours within their setting
- develop planning tables identifying productive and non-productive hours relevant to maternity services
- identify and describe client and service complexity and activity indicators to improve consistency in the application of the BPF 5th Edition in maternity services



Module 1: Development of a service profile

This section relates to BPF 5th Edition module 1: pages 13-26

Business planning in the context of maternity services

There are a number of common midwifery and nursing workload management and workforce planning issues within maternity services. These are recognised nationwide as critical areas of concern. The most frequently discussed issues involve:

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

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, it is recognised some women and their babies may need to travel outside their local community

to access necessary care.² A woman and her baby's health require ongoing evaluation at each of the following stages of care:

- at booking
- during pregnancy and the antenatal period
- during labour and birth
- during the postnatal period.³

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

- 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; and,
- a sufficient midwifery workforce to allow backfill for leave, training and professional development

¹ Coates, A. C., 2010, *Characteristics of National Maternity Services Capability Framework*, Queensland Health, 12 December 2010, on behalf of the Maternity Services Inter Jurisdictional Committee for the Australian Health Ministers' Advisory Council.

² https://www.health.qld.gov.au/__data/assets/pdf_file/0024/444273/cscf-maternity.pdf

³ https://www.health.qld.gov.au/__data/assets/pdf_file/0024/444273/cscf-maternity.pdf

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

- child health services such as,
 - » child health immunisation schedule
 - » hearing screening facilities and assessment,
 - » perinatal mental health, and,
- access to Child Safety Services.⁴

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

The calculation of productive hours needs to incorporate staffing requirements for direct and indirect activities that may not regularly occur in other health settings (refer to Table 2: Key productive and non-productive midwifery and nursing hours). These requirements further emphasise the importance of professional judgement in the calculation of the productive midwifery and nursing hours.

Other key considerations in the maternity setting

Benchmarking

- Benchmarking of service activity and relative performance measures within maternity services are complex and affected by clinical information systems or differing performance reporting frameworks.
- The ability to articulate and review benchmarking data is further challenged by maternity services unique partnership with private services; this varies throughout the state with some having co-located facilities and others sharing the same unit space.

- Benchmarking can also be challenging within maternity settings due to the varied models of care across the state and within the same Hospital and Health Services (HHS), with information being impacted by where the model is delivered, and the philosophy of care and the influence on maternity services team.
- 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. Australian Institute of Health and Welfare are currently looking to develop a nationally linked data collection system of these models.
- Current data used for benchmarking is based on clinical outcomes (e.g. Perinatal Data Collection). On their own, these are not an effective method as they may not adequately reflect elements which impact care including comorbidities, geographic location or the health practitioner providing the care. For appropriate benchmarking, like models should be compared to like models.
- Nurse sensitive indicators⁵ do not encompass midwifery models at present however midwifery sensitive indicators are under consideration.

Infrastructure

- Ageing building infrastructure and building design impacts upon workflow efficiency, occupational health and safety, and security of staff
- Disparate clinical information systems impact on recording of activity and subsequent data reliability. This includes quantitative methods to individually measure midwifery and nursing workloads.
- The limited physical infrastructure in facilities at times strongly influences the ability to provide models of care that ideally suit the community demographics and community expectations e.g. baths and water birthing facilities.

⁴ https://www.health.qld.gov.au/_data/assets/pdf_file/0024/444273/cscf-maternity.pdf

⁵ http://paweb.sth.health.qld.gov.au/nursing/dss_nsi_packs.asp

- The physical location of the units that the woman will progress through, such as antenatal, birth suite/operating theatre and postnatal, has an impact on time spent transferring care. This is a particular challenge when located on different floors, different buildings or in the community setting.
- Appropriate location of equipment to support evidence based practice can vary, for example, the inbuilt 'cosy cabinets' in birth suite contain resuscitation equipment and reduces the time taken to locate and redistribute the equipment required for every birth.
- Inefficiencies with access to QFleet vehicles means additional indirect time is spent locating appropriate transport resources, and in some cases, requires the use of personal vehicles.

Technology

- Not all facilities have sufficient technology infrastructure (including mobile network coverage, reliable internet coverage and Wi-Fi) to support digital platforms used by maternity services and the maternity consumers.
- The impact of over 50 digital systems within maternity statewide has been identified as an area of particular disruption. Some of the issues identified are the time to not only use the system but also different logins and duplication of documentation. Limited access to technology at the point of care impacts on midwifery and nursing workloads, which can be further compounded by the physical layout of the unit and distances travelled by the midwives and nurses.
- The development of apps to meet the expectations of the maternity population and improve women's care can shift the care from clinic to home and changes the demand and care provided by the midwives and nurses. This can increase or decrease demand on the midwife or nurse depending on the stage of technology development.

Funding models

- The traditional funding model focuses on interventional care; however maternity services are based on a wellness model. Activity Based Funding models generally support intervention as opposed to primary health care models.
- Significant remote midwifery workforce resourcing implications exist in association with traditional service delivery implementation of National Maternity Services Plan 2010⁶ and the increasing consumer expectations for evidence based Continuity of Care midwifery models in remote communities.
- Utilising a growing midwifery workforce who are able to prescribe is an important consideration.

Recruitment, retention and succession planning

- Due to limitations in data, the true impact of retirement risk for midwives is unknown
- Variation in opportunities for undergraduate midwifery students to have clinical placements in continuity models across the state. This may have implications on retention and the attraction of the future workforce.
- Opportunities to work to full scope of practice in continuity models of care vary, and has implications on attracting and retaining the midwifery workforce.
- Graduates are fundamental in succession planning; however adequate education infrastructure must accompany growing graduate numbers.
- There is currently no access to private practice for midwives to join the public sector workforce, and provide private midwifery services as is available in the medical workforce.

⁶ <http://www.health.gov.au/internet/main/publishing.nsf/content/maternityservicesplan>

- There may be the requirement to undertake additional mandatory training or education in line with the CSCF requirements, and this has implications on the number of indirect midwifery and nursing hours required.
- Consideration needs to be given to the resources required to support models that span multiple locations (e.g. rural and remote continuity of care models) and supplementary Telehealth Emergency Management Support Unit (TEMSU) support.
- In some areas, there is limited access to a casual workforce for the management of emergent leave and short term planned leave.

Models of care

- Midwifery continuity models may include work that has historically been done by other health professionals and services outside of maternity, for example immunisation, sexual health screening and family planning. Incorporation of the time associated with this increased in activity must be considered in the context of workforce planning and service delivery.
- Models of care that enable a midwifery workforce to work to full scope of practice provides for significant improvement of women and babies health and wellbeing outcomes, workforce satisfaction and cost efficiencies. Moving maternity care out into the community in this way provides for many benefits to the workforce, women and their families and the organisation.



Business planning considerations

This section relates to BPF 5th Edition Module 1.4: page 15

The BPF 5th Edition outlines the general factors a service should consider when analysing the internal and external environment as part of developing their service profile. However, there are a variety of business planning factors which influence the maternity services and result in service demand fluctuations. These internal and external factors need to be considered when analysing service demand. Wards and services should annually assess the impact of each factor on their environment and make the necessary adjustments to the allocation of midwifery and nursing hours.

Table 1 provides examples of several business planning considerations relevant to the maternity services, based on recognised internal and external influences. Consideration of the impact and level of influence these have on midwifery and nursing workloads to support the productive hours is required.



Table 1: Business planning consideration for maternity services

Influences (internal and external)	Service impact	Examples of workload management considerations
<p>Locality of service (Internal) (Metropolitan, regional, rural and remote)</p>	<p>The locality, type and catchment area of a service will influence the balance of service demand and supply.</p> <p><i>Examples:</i> <i>The CSCF level for maternity services will determine the transfer protocols for mother and baby requiring specific levels of specialised care. This may impact on midwifery and nursing resources of the service transferring and receiving the mother and baby.</i></p>	<p>Direct nursing and midwifery hours: Calculation of clinical hours for direct care, allocation of clinical hours (rosters), selection of service activity/acuity measures, use of minimum safe staffing requirements</p>
<p>Type of service (Internal) (e.g. outpatient departments,</p>	<p><i>Rural and remote facilities that have limited or no maternity service/resources are impacted when pregnant women need emergent management or care at a local level. The impact on the facilities funding and resource allocation is limited to CSCF criteria.</i></p>	<p>Indirect nursing and midwifery hours: Calculation of clinical hours for indirect care, travel, program/service based education, succession planning, quality activities and research</p>
<p>Catchment area (Internal)</p>	<p><i>Diversity of some maternity services requiring midwives to care for non-maternity patients requires appropriate skill mix and allocation.</i></p>	<p>Workforce planning: Development of strategic local/statewide workforce plans to inform FTE requirements, skill mix profiles and macro workforce planning formulas.</p>
<p>Nursing and midwifery structure (Internal) (Roles, functions, accountabilities and relationships between all categories of nursing and midwifery staff)</p>	<p>The model of care selected for a service will influence the midwifery and nursing support structures required. Midwifery and nursing roles, and how they relate with other clinical roles, will impact on the balance of service demand and supply.</p> <p><i>Examples:</i> <i>Consideration of the social and behavioural support required of each individual woman and her family.</i> <i>Individual education and ongoing support once discharged from hospital will vary dependent upon geographic region dependent upon service availability.</i></p>	<p>Direct nursing and midwifery hours: Calculation of clinical hours for direct care provided in and outside the service, position classifications for the clinical hours required, allocation of clinical hours (rosters), selection of optimal service activity/acuity measures, safe staffing levels.</p>
<p>Support structure (Internal) (Providing support to other services and/or receiving support from other services)</p>	<p><i>The accessibility to maternity services and the level of support required will vary and the NHPPD should reflect this.</i> <i>Limited midwifery workforce to cover emergent leave, backfill and increase in acuity and activity or increase in patient numbers (i.e. capacity management).</i></p>	<p>Indirect nursing and midwifery hours: Calculation of clinical hours for non-direct care networking/collaboration (internal and external) travel, staff training, professional development, quality activities and research.</p>
<p>Model of care (Internal) (Multi-functional teams)</p>	<p><i>Aging midwifery workforce and prospective retirement risk needs consideration. Support required for the novice and advanced beginner in continuity models of care must be included in the Service Profile (e.g. need for Clinical Facilitators).</i> <i>Consideration of succession planning strategies for continuity of care models.</i> <i>Consumer expectation of increased availability of continuity of care models</i> <i>Impact on models of care of midwives undertaking part-time work</i> <i>Non-maternity outliers to maternity services and requiring midwives to work under the delegation of registered nurses.</i></p>	<p>Workforce planning: Development of role descriptions and skill mix profiles suitable for the context of practice (internal and external) to the service. Devising operational and organisational structures to support staff in applying the chosen model of care. Development of operational workforce plans to inform FTE requirements and macro workforce planning formulas.</p>

Table continued overleaf »

Table 1: Business planning consideration for maternity services (continued)

Influences (internal and external)	Service impact	Examples of workload management considerations
<p>Policy/legal factors (External)</p>	<p>Changes in health policy and legislation will influence service delivery and staff requirements. Common change drivers include governments (Commonwealth/ State), licensing organisations, professional and industrial groups.</p> <p><i>Examples:</i></p> <p><i>Legislation – Work Health and Safety Act 2011, Child Protection Act 1999, Mental Health Act 2015</i></p> <p><i>Commonwealth - health reform</i></p> <p><i>The National Framework for Protecting Australian Children 2009-2020</i></p> <p><i>Queensland Health – strategic plan</i></p> <p><i>Clinical Service Capability Framework</i></p> <p><i>Professional Standards such as Australian College Midwives.</i></p> <p><i>Australian Health Practitioner Regulation Agency (AHPRA).</i></p> <p><i>Nursing and Midwifery Board Australia</i></p> <p><i>Australia College of Midwives “National Midwifery Guidelines for Consultation and Referral”.</i></p> <p><i>Baby Friendly Health Initiative (BFHI)</i></p> <p><i>Ryan’s Rule</i></p>	<p>Direct nursing and midwifery hours:</p> <p>Calculation of clinical hours for direct care (based on available funding), position classifications for the clinical hours required, registration commitments for clinical hours, allocation of clinical hours (rosters), selection of optimal service activity/ acuity measures, and use of minimum staffing requirements.</p>
<p>Economic factors (External)</p>	<p>Funding policies, the national economy and the interface between public and private health care providers will influence the maternity services provided and the number of staff required.</p> <p><i>Examples:</i></p> <p><i>Service improvement initiatives can provide non-recurrent funding increases for services which achieve the targeted results. These incentives could impact the skill and number of midwives and nurses required for service delivery.</i></p> <p><i>Transfer from private hospital to public hospital due to acuity or inability for the private facility to provide the required level of care for the woman and baby.</i></p>	<p>Indirect nursing and midwifery hours:</p> <p>Calculation of hours for indirect and non-productive activities such as policy development, business planning, service interfaces, travel, staff training, professional development, quality activities and research.</p>
<p>Social/population factors (External)</p>	<p>Population demographics and community expectations will impact on maternity resources/ services and how services are offered, staffing numbers and skill mix required for service delivery.</p> <p><i>Examples:</i></p> <p><i>Delivering health services to a community with a high proportion of non-English speaking people will impact the number and type of clinical hours required to provide the service.</i></p> <p><i>Increased consumer expectation to deliver evidence based models such as continuity of care.</i></p> <p><i>Cost of accommodation and transport for women who need to leave their community to birth. Emotional and social support for these women and their family.</i></p> <p><i>Planning care for women, who have chosen care outside of recommended guidelines and, those with limited antenatal care.</i></p> <p><i>Cultural diversity expectations around maternity care and delivery.</i></p>	<p>Workforce planning:</p> <p>Development of role descriptions and skill mix profiles suitable for the context of practice (internal and external) to the service.</p> <p>Devising operational and organisational structures to support staff in applying the chosen model of care.</p> <p>Development of operational workforce plans to inform FTE requirements and macro workforce planning formulas.</p>

Midwifery and nursing core demand considerations

To improve the consistency and transparency in the application of the BPF 5th Edition, specific demands on direct and indirect midwifery and nursing hours in maternity services have been categorised to assist in articulating midwifery and nursing work. The categories are based on the most common and frequent demands placed on midwives and nurses within maternity services. The following section will explore the relationships between core demand considerations and the context of practice in maternity services.

Client/service complexity

When reviewing client or service complexity, in the BPF Service Profile, there are a number of unique considerations for maternity services, these include;

- holistic care of the woman incorporates social, emotional, spiritual and psychological care
- care is not limited to the care of the woman only, the neonate also requires midwifery or nursing hours
- recognition should be given to increased acuity and activity associated with care of the newborn
- culturally safe care of Aboriginal and Torres Strait Islander women and their family
- complexities of caring for culturally and linguistically diverse women requires consideration of cultural safety needs for the woman and her family
- maternity services unable to deliver all service levels in the local community due to the CSCF criteria, workforce issues
- non-maternity outliers being cared for in a maternity service setting and requiring midwives to work under the delegation of registered nurses
- women who are expecting more than one baby (e.g. multiple births, twins) require extra midwives to manage the birth and meet CSCF requirements.⁷ The majority of multiple births are preterm and are more likely to require a higher level of care, with admission of babies to a special care nursery or neonatal intensive care unit.⁸
- women have the choice about their preferences for maternity care, based on the ethical principle of autonomy⁹
- that midwives and nurses should undertake a search of systems where the Unborn Child High Risk Alert may be recorded e.g. toolkit (folder) every time a pregnant woman is admitted for birthing¹⁰
- research suggests that women are at greater risk of experiencing violence from an intimate partner during pregnancy and post-partum¹¹
- women from lower socioeconomic areas are more likely to begin antenatal care later in pregnancy, be overweight, and smoke during pregnancy. These factors put them at higher risk of complications. They are more likely to birth early and have babies with a lower birth weight^{12 13}
- obesity during pregnancy which puts women at risk of gestational diabetes (and therefore increased risk of caesarean section), pre-eclampsia and sleep apnoea¹⁴

⁷ https://www.health.qld.gov.au/__data/assets/pdf_file/0024/444273/cscf-maternity.pdf

⁸ <https://www.ncbi.nlm.nih.gov/books/NBK83112/>

⁹ <https://www.ncbi.nlm.nih.gov/pubmed/24282854>

¹⁰ <http://qheps.health.qld.gov.au/policy/docs/gdl/qh-gdl-949.pdf>

¹¹ <https://aifs.gov.au/cfca/publications/domestic-and-family-violence-pregnancy-and-early-parenthood>

¹² <https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies-2015-in-brief/contents/table-of-contents>

¹³ <https://www.ncbi.nlm.nih.gov/books/NBK83112/>

- smoking during pregnancy is associated with poorer perinatal outcomes including low birthweight, being small for gestational age, pre-term birth and perinatal death¹⁵
- pregnant women aged 35 years and older face various risks including genetic disorders, prenatal medical and obstetric complications, intrapartum complications, and perinatal and neonatal morbidity and mortality. With each passing year, the risk of chromosomal abnormality such as Down's syndrome increases.¹⁶
- the use of illicit drugs early in pregnancy can cause birth defects and miscarriage. During the later weeks of pregnancy, illegal drug use can interfere with the growth of the foetus and cause preterm birth and foetal death.¹⁷

Model of care/service delivery

The MaCCS, was developed as part of the National Maternity Data Development Project to provide a comprehensive classification system for maternity models of care operating in Australia.¹⁸ QH and QNMU, in partnership, as part of enterprise bargaining, are undertaking bodies of work to enhance data collection and to describe contemporary midwifery models of care. This involves statewide projects examining maternity models and workforce within Queensland maternity services.

It is essential to clearly articulate the models of care / service delivery in the service profile, examples of current maternity services in HHSs include:

- midwifery-led continuity of care models (e.g. caseload midwifery, midwifery group practice [MGP])
- General Practitioner (GP) share care
- standard hospital care, including: inpatient care (birthing suite, post-natal ward, neonatal intensive care [NICU], special care nursery [SCN], operating theatres)

- Birth Centres
- community and hospital based antenatal clinics
- lactation services

Technology and materials management

The introduction of digital systems and e-health technology requires significant input from midwives and nurses. Often systems require modification to meet the needs of maternity services, resulting in staff needing to assist other streams to customise the systems, for example, the introduction of ieMR across the domains of maternity care. The time that is spent on accessing and recording of information on a number of systems also needs to be considered.

Additional considerations for the impact of technology and materials management need to be included when calculating indirect midwife and nursing hours. Examples include;

- multiple computer programs not communicating requiring duplication of data input
- telehealth - equipment set-up, preparation of the woman and family, consultation assistance
- input into development of apps for maternity care
- assets management of specialised equipment including obtaining quotes, maintenance coordination, education and implementation of new technology/equipment, yearly asset stocktake
- imprest and drug management processes
- management, availability and ease of access to donor breast milk

¹⁴ <https://www.acog.org/Patients/FAQs/Obesity-and-Pregnancy>

¹⁵ <https://www.aihw.gov.au/getmedia/728e7dc2-ced6-47b7-addd-befc9d95af2d/aihw-per-91-inbrief.pdf.aspx?inline=true>

¹⁶ <https://www.ncbi.nlm.nih.gov/pubmed/12317779>

¹⁷ <https://www.acog.org/Patients/FAQs/Tobacco-Alcohol-Drugs-and-Pregnancy#drug>

¹⁸ <https://www.aihw.gov.au/reports/mothers-babies/maternity-care-classification-system-maternity-mo/contents/table-of-contents>

Community interface

Community and consumer engagement is pivotal to the delivery of the appropriateness, effectiveness, quality, and safety of maternity care. Maternity care has a variety of service delivery models which provide women and their families with options. Some of the options offer women to be cared for in a community setting.

The ward/unit/service may directly or indirectly interact with the following groups

- Aboriginal Community Controlled Health Service (ACCHS)
- Hospital in the Home and extended midwifery services
- private practice midwifery models
- Community Based Child Health Centres
- local GPs
- government agencies, such as Department of Community Services and Child Safety teams
- local consumer liaison / reference group for maternity services

The time that staff spend to liaise and collaborate with community groups need to be considered when calculating productive hours.

Quality and safety

Quality 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. This distribution of direct and indirect hours needs to be contextualised for the service based on variables such as type of service delivered, model of care, population dynamics staff competency requirements, and location of unit or program where delivered.

Some key quality and safety components which may impact productive midwifery and nursing hours include;

- 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
- application of the National Safety and Quality Health Service Standards
- introduction of changes to evidence based guidelines
- policy, procedure and clinical guideline development and review
- management of Ryan's Rule requests
- implementation of Root Cause Analysis (RCA), Human Error and Patient Safety (HEAPS) outcomes
- incident and 'near miss' reporting and challenges with family behaviours
- mandatory and requisite training requirements for midwives and nurses working in maternity services

This is not a complete list but individual facilities need to incorporate the time taken for quality planning and incident management processes when completing the Service Profile.

Education and service capacity development

The CSCF identifies training and credential requirements for midwives and nurses working in maternity services. When completing the Service Profile, consideration should be given to the CSCF modules that are relevant to the individual facility for establishing and planning the requisite training requirements.



Considerations for maternity services can include;

- additional training requirements for midwives and/or nurses (e.g. PROMPT,¹⁹ water immersion, neonatal resuscitation, foetal surveillance education program, breast feeding, safe sleeping, domestic violence awareness, child safety, Drug Therapy Protocol – Midwives,²⁰ examination of the newborn)
- adequate backfill to release staff to attend training
- clinically based facilitators/coaches to assist with graduate or novice midwives for sufficient clinical and professional support
- Baby Friendly Hospital Initiative (BFHI) requirements – midwives need to provide multidisciplinary training to all professional groups across hospitals and other campuses
- travel time to attend training that is not provided locally
- staff engagement in succession planning
- availability of midwife student positions or placements

For student midwives to complete their education and professional preparation, as well as post graduate midwives consolidating their education, placements need to be available

with sufficient support both clinically and professionally. Mentoring pathways and clinical supervision may be a component of ongoing staff development and support.

Leadership and management

Antenatal, intrapartum and postnatal care can be delivered in a variety of settings, depending on the model of care chosen by the woman and her partner, the CSCF criteria, the acuity of the pregnancy, and the geographical location of the pregnant woman. As such, consideration needs to be given to the individual leadership and management requirements and the support systems within the maternity service. This 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, caseload midwives)
- limited time available for leaders to communicate and engage with internal and external partners regarding models of care and service delivery
- limited indirect hours available to participate in strategic and operational planning

¹⁹ <http://www.promptmaternity.org/>

²⁰ https://www.health.qld.gov.au/_data/assets/pdf_file/0027/443097/dtp-midwives.pdf

- limited midwives in senior leadership roles
- availability of backfill to support leadership development
- facilitating a peer support network for Maternity Unit Managers, Clinical Midwife Consultants and Nurse/Midwife Educators across the state
- time for collaboration with multidisciplinary leaders
- articulating the role of team leaders and allocating appropriate midwifery and nursing hours
- advocating and negotiating for evidenced based practice where woman-centred care is poorly understood
- Understanding of contemporary midwifery models of care

Research and evidence based practice

Undertaking research and evidence based practice activities will influence the number of indirect midwifery and nursing hours required for service delivery. Research and evidence based practice is essential to improve the standards of care that will produce better health outcomes for women and their babies.

Consideration needs to be given to the impact on midwifery and nursing hours spent undertaking tasks associated with research projects, and implementing outcomes into the clinical setting. Establishing a multidisciplinary team approach in line with best evidence and woman centred care requires team building along with time to review and update practice.

Health policy, clinical guidelines, strategic plans and health legislation

There are a number of legislative and policy requirements that influence the maternity setting. These should be considered when developing service profile, resource allocation and evaluation of performance.

Key examples are;

- Primary Maternity Services in Australia: A framework for implementation²¹
- ACM Guidelines for consultation and referral²²
- National Maternity Service Plan²³
- Statewide Maternity & Neonatal Clinical Services Guidelines²⁴
- Closing the Gap²⁵
- Immunise Australia Program²⁶
- Drug Therapy Protocol – Midwives²⁷
- Nursing and Midwifery Board of Australia Decision-making Framework²⁸
- Nursing and Midwifery Board of Australia standards for practice²⁹
- Australian Government Department of Health – Maternity Services³⁰
- localised HHS policies, procedures and protocols
- localised HHS strategic plans

²¹ Australian Health Ministers' Advisory Council (AHMAC). *Primary Maternity Services in Australia: A Framework for Implementation*. Canberra: AHMAC, 2008.

²² <https://www.midwives.org.au/resources/national-midwifery-guidelines-consultation-and-referral-3rd-edition-issue-2>

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³⁰ <http://www.health.gov.au/maternity>

Module 2: Resource allocation

This section relates to BPF 5th Edition Module 2: pages 27-47

Establishing total midwifery and nursing resource requirements

STEP 1	Calculate total annual productive nursing and/or midwifery hours required to deliver service.	Go to BPF 5 th Edition page 31
STEP 2	Determine skill mix/category of the nursing/ midwifery hours.	Go to BPF 5 th Edition page 35
STEP 3	Convert productive nursing/midwifery hours into full-time equivalents.	Go to BPF 5 th Edition page 38
STEP 4	Calculate non-productive nursing and/or midwifery hours in accordance with nursing and midwifery award entitlements.	Go to BPF 5 th Edition page 39
STEP 5	Convert non-productive nursing and/or midwifery hours into full-time equivalents.	Go to BPF 5 th Edition page 43
STEP 6	Add productive and non-productive full-time equivalents together and convert into financial resources in partnership with business team.	Go to BPF 5 th Edition page 44
STEP 7	Allocate nursing and/or midwifery hours to meet service requirements.	Go to BPF 5 th Edition page 47

Productive midwifery and nursing hours include both 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 Full-Time Equivalent (FTE) required.

Creating a list of standard direct and indirect midwifery and nursing activities in your unit or practice area will assist in articulating and monitoring the use of productive hours. As outlined in the BPF 5th Edition, this consultation process should be undertaken with unit staff.

Information gathered about productive hours can be used to inform a number of service requirements such as staffing numbers, skill mix, models of care and education/training programs. It is important to document all midwifery and nursing activities relevant to your service, especially those considered unique to

your unit or practice area. Defining productive hours increases the understanding of the midwifery and nursing work being performed and provides an excellent foundation when developing a service profile.

Total productive hours =



direct hours

+

indirect hours

Table 2 provides examples of key productive and non-productive midwifery and nursing activities for maternity services, and should be used in conjunction with the BPF 5th Edition (pages 27-47).



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
Woman and baby assessments in inpatient setting (emergency presentation of the pregnant woman)	x			Monitoring, and woman and foetal assessment
Case management	x			Caseload midwives, antenatal clinics, high risk women, 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

Table continued overleaf >>

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

Activity	Productive		Non-Productive	Examples
	Direct	Indirect		
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, foetal demise
Follow ups		x		Post birth, supporting women who chose to options outside of recommended guidelines
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 collecting and 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/speciality 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)		x		Participation in PAD process and Performance Improvement Process (PIP)
Succession planning		x		Workplace shadowing, professional development
Staff meetings		x		Unit/ workplace based
Evidence-based practice		x		Research activates/service based projects

Table continued overleaf >>

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

Activity	Productive		Non-Productive	Examples
	Direct	Indirect		
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
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 plant maintenance		x		Obtaining quotes, ordering of equipment for service 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 indirect hours. Clinical hours associated with mandatory training and professional development leave for education purposes is allocated within non-productive hours.

Service activity

Financial activity does not always easily or directly translate into nursing and midwifery activity. In the maternity setting the roles of midwives and in some facilities nurses, span across the continuum of care and management of a pregnant woman to six weeks post birth. This depends on the CSCF for that particular facility.

For example in the maternity setting midwives are providing:

Antenatal care: Antenatal care is referred to care provided to a pregnant woman before birth. Midwives are required to provide antenatal care in a variety of settings. This will depend on the individual facilities Model of Care and service delivery they provide for pregnant women.

Some midwives will be required to undertake antenatal care including antenatal classes in a community setting away from their primary place of work.

**Please refer to Appendix 1, which identifies antenatal activity measures for providing antenatal care.*

Intrapartum Care: Intrapartum care refers to the care given from the onset of labour to the immediate care post birth. Midwives provide Intrapartum care and management according to the CSCF of their facility and the Model of Care the women has chosen. Intrapartum care can be in a hospital birthing suite or birth centre. The Birth Centre may or may not be attached to the hospital which is solely managed by experienced midwives. It is expected that 1:1 care is provided to all women during labour.

**Please refer to Appendix 1 which identifies the midwifery measured activity for proving Intrapartum care.*

Postnatal care: Postnatal care refers to the care of the mother and newborn from birth to 6 weeks. Depending on the Model of Care the woman accesses and the outcome of the birth and wellbeing of the new born, the length of stay and care required will determine the midwifery hours needed.

**Please refer to Appendix 1 which identifies the midwifery measured activity for providing Post-natal care.*

Special Care Nursery: The level of nursery care is determined by the facilities CSCF. Not all facilities follow the same criteria for admission to a special care nursery. Midwives are predominately responsible for the well new born postnatally until discharge. The staffing requirements will depend on the acuity and CSCF level of each individual nursery.

**Please refer to Appendix 1 which identifies the midwifery/nursing measured activity for a Special Care Nursery*

Home Visiting: Home visiting or Extended Midwifery Service is conducted by midwives according to the Model of Care the woman accessed/received. Each facility that provides home visiting post birth has to take into consideration, the availability of staff, cars and the geographical distance and road conditions. Home visiting often has to be prioritised as the midwifery hours allocated and available in non caseload models is not enough to cater for the demand. Pre planning requirements, which incorporates undertaking a comprehensive file review and risk assessment, for a visit is time consuming for the midwives.

**Please refer to Appendix 1 which identifies the midwifery measured activity for a Home Visit.*

Day Assessment Unit: Not all facilities have a day assessment unit. This could be allocated rooms close to or in birth suite. Many activities that midwives have to undertake in this area is administrative. After hour's pregnant women requiring monitoring or assessment, but not in labour are placed into the birth suite adding extra workloads for the birth suite midwives.

**Please refer to Appendix 1 which identifies the midwifery measured activity for Day Assessment Unit*

For the rural and remote facilities this may also incorporate stabilization and transfer of the pregnant women, or a neonate and post-partum woman.



Module 3: Evaluation of performance

This section relates to BPF 5th Edition Module 3: page 48-54

Data collection for maternity services

Data collection supports the measurement of clinical outcomes, financial outcomes and service performance and partially, workload demand. The available information systems may not always capture the data required for conducting a comprehensive environmental analysis of midwifery and nursing in the maternity services. Table 3 outlines key identified information systems available in the maternity services, they may not provide the required information so local data bases or spread sheets may be developed.



Table 3: Maternity services information systems and data collections

Information system/ collection	Purpose	Informs
* Elective Admissions Management System (HBCIS module)	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.	Waitlist management bookings
Auscare	Pathology	Accessing pathology results
Auslab	Pathology	Accessing results
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 and work centres. http://dss.health.qld.gov.au/	Workforce Expenditure Performance
EDIS / FirstNet	Emergency Department system	Maternity triage
Electronic Discharge System (EDS)	Enterprise system for automated discharge summaries	GP access to discharge information
Electronic Patient Journey board	Used in some facilities to manage patient flow	Patient flow Discharge planning
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. http://qheps.health.qld.gov.au/eds/home.htm	Client trends Client complexity Client outcomes Performance
Enterprise scheduling system (ESS)	Upgraded outpatient scheduling module used with electronic medical records	Appointment scheduling
ERIC – Hybrid electronic medical record management system	Used in some health services as partial electronic medical record	Access to clinical information
eRM	Electronic referral management system	Referral management
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. http://qheps.health.qld.gov.au/id/	Activity Workforce Services Performance Client demographics Referral/waitlist - Financial reporting
iMED	An online network of 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

Table continued overleaf >>

Table 3: Maternity services information systems and data collections (continued)

Information system/ collection	Purpose	Informs
iPharmacy	Pharmacy management system	Medication management
ISIS	Interpreter services information system	Interpreter services
MATIS	Online system for electronically capturing and submitting perinatal data and birth registrations	Perinatal data capture
MIS	Maternity information system for electronic recording of patient encounters throughout pregnancy	Encounters during pregnancy
McKesson Capacity Planner (West Moreton, Townsville and Metro South)	An on line tool used to forecast patient demand and align staffing resources	Workload allocation Capacity management
Medicare on line	Used for checking eligibility for services	Medicare eligibility Medicare numbers
Monthly Activity Collection (MAC) Note: MAC reporting to become obsolete in 2018/19	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 routinely reported on Queensland Health’s internet and internet sites. http://www.health.qld.gov.au/hic/manuals/MAC/2012/12_13_mac_final.pdf	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 eg leave form. Managers have access to their establishment and rostering practices, plus Hr reports and electronic leave approval.	Workforce management
ORMIS/SurgiNet	Operating Rooms data and patient information system	Minutes in operating theatre/recovery Fatigue management
Outlook	Email and personal appointment management	Email and meeting management
Outpatient Services Information Management System (OSIM)	Customer service focused system that assists clinicians to manage waiting times, administration processes, clinical statics and patient appointments. http://paweb.sth.health.qld.gov.au/dts/training/documents/osim_manual_1.pdf	Session type Care type Delivery setting Clinic type Service type Service delivery Activity Referral/waitlist Financial reporting
PACS –(Picture Archive and Communication system)	medical imaging technology which provides economical storage and convenient access to images from multiple modalities	Access to scans and medical imaging

Table continued overleaf >>

Table 3: Maternity services information systems and data collections (continued)

Information system/ collection	Purpose	Informs
Patient Flow Manager	System which displays admitted patient status and electronic journey board	Patient occupancy dashboard
Perinatal DataOnline (PNO)	System to enter key perinatal data on a monthly bases which feeds into a statewide maternity reporting	Models of Care Clinical Data Benchmarking BFHI data Acuity activity Clinical Indicators
Practix	Records data relating to client demographic, clinical notes, investigations, correspondence and billing requirements	Activity Workforce Services Performance
Primary Related Incident Management and Evaluation System (PRIME)	Management of clinical incidents and health care complaints http://connect.health.qld.gov.au/prime/	Performance Service safety Client outcomes
QFlow	Automated arrival system	Patient check ins
QHERS	Queensland health electronic reporting system through which Queensland Health employees can access a number of custom made statistical reports.	Statistical reporting
Qmanager	Outpatient Appointment Management System to be released	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. http://qheps.health.qld.gov.au/hic/dsu_collections.htm	Activity Client complexity Client trends Performance Client outcomes Funding
RADNET	Radiology system aligned to iEMR which allows viewing of radiology report and diagnostic medical images.	Radiology reporting
RiPS	Radiology system which allows viewing of radiology reports and diagnostic medical images statewide – replaced by RADNET in line with iEMR	Radiology reporting
RiskMan	Replacing PRIME with a staged release over 2017-2018 throughout each HHS	Performance Service safety Client outcomes Staff outcomes Consumer feedback system

Table continued overleaf »

Table 3: Maternity services information systems and data collections (continued)

Information system/ collection	Purpose	Informs
SPR	Service performance and reporting	Statistical reporting
STS	Secure transfer service for transferring and receiving information to and from external parties.	Information transfer
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
TIS	Telstra integrated messaging system	Messaging services
TrendCare	Information System for staff allocation, patient acuity data and staffing level requirements.	Acuity Patient Escorts N/MHPPD Admin Non nursing duties Verify indirect hours Workload allocation Efficiency Reports



As per the BPF 5th Edition, when a balanced scorecard is available, it assists in identifying service objectives, selecting appropriate performance measurements and monitoring the progress of those objectives. The balanced scorecard highlights both successful and unsuccessful performance trends and allows service comparisons to be made internally and externally. If a balanced scorecard is not available it will be necessary to determine local performance indicators.

There are a number of midwife and nurse sensitive indicators suitable for evaluating the quality of maternity services such as:

- staff experience measures
- woman and baby experience measures
- health screening processes and outcomes
- clinical incidence reviews
- readmission rates
- Hand Hygiene compliance
- number of births attended by midwives
- number 3rd 4th degree perineal tears
- percent of women receiving Continuity of Care
- exclusive breast feeding at discharge
- National Maternity Core Indicator

Examples of workforce specific quality indicators in the maternity setting include;

- MaCCS
- vacancy rates
- staff turnover
- overtime utilisation
- casual/agency hours
- workload concerns
- absenteeism
- mandatory training completion rate
- postgraduate and student midwife completion rates

Key performance indicators should be chosen based on the individual service, with consideration to the consumer, staff, and the greater organisation.

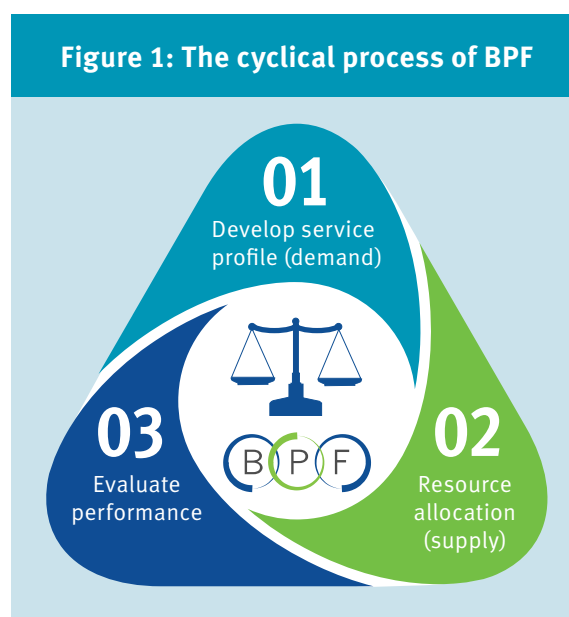
Measurement of performance should include quality indicators including results from accreditation cycles and periodic reviews, further examples can be seen on page 50 of the BPF 5th Edition.

Forecasting and benchmarking

In the maternity setting, as there are no standardised data sets, benchmarking can prove challenging. In the absence of reliable benchmarking, the evaluation of performance can be used to inform forecasting in maternity settings.

Some health services contribute to data sets such as Women’s Health Australasia (WHA) and /or Health Round Table. The value of data varies as each service is unique and has individual variables making meaningful comparisons between the services challenging. All health services are required to contribute to Queensland Health Perinatal data collection.

A key component of the BPF cycle is evaluating performance, this 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.



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<https://www.legislation.gov.au/Details/C2006C00104>

Appendix 1: Example activity measures identified for maternity services

Clinics – antenatal, specialist

- number of appointments (new and review)
- Out of hours clinics and number of Occasions of Service (OOS) (consideration for penalty rates)
- number of Fail To Attends (FTAs)
- number and location of community clinics
- number of pathology specimens collected
- number of procedures attended
- number of assessments (e.g. 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 follow up appointments
- 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
- number of Gestational Diabetes Mellitus clinics
- 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

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 Haemorrhages (PPH)
- number of multi vs. primipara
- number of vaginal births after caesarean (VBAC)
- number of after-hours OOS for BFHI
- proportion of women and babies with skin to skin contact - BFHI
- number of women where breastfeeding initiated in birth suite
- length of stay 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 birth registrations completed
- number of episodes of education delivered in birth suite
- number of women requiring interpreter
- number of multidisciplinary students ie 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
- percentage of labour and birth attended by primary midwife
- early labour home assessment

Ward

- number of home visits
- number of inductions of labour
- number of termination of pregnancies
- number of still births
- number of complex care (e.g. Gestational Diabetes Mellitus [GDM])
- number of birth registrations
- number of healthy hearing tests
- number of vaginal births after caesarean (VBAC)
- number of Post-Partum Haemorrhages (PPH)
- Hours Per Patient Day
- Occupied Bed Days, Fractional Bed Days
- Length of Stay
- number of separations
- number of telephone consultations
- number of outlier patients cared for in maternity ward
- number of ward review OOS
- number of examination of newborns completed
- number of episodes of parent education
- number of babies requiring paediatrics review in ward setting
- number of unqualified babies
- number of babies admitted to Special Care Nursery from ward
- number of unborn child high risk alerts

Special Care Nursery

- number of episodes of parent education
- number of babies on invasive ventilation
- number of babies on non-invasive ventilation (CPAP)
- number of telephone consultations
- Hours Per Patient Day

- Occupied Bed Days, Fractional Bed Days
- Length of Stay
- number of separations
- Diagnostic Related Groups
- GDM monitoring
- number of funded cots
- gestation on admission (including adjusted age)
- number of episodes for monitoring baby after GDM
- number of resuscitations
- number of retrievals
- utilisation and management of Expressed Breast Milk (EMB)

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 whom home visits are provided to (e.g. up to six weeks)

Day Assessment Unit

- number of pathology specimens collected
- number of procedures attended
- number of assessments (e.g. CTG) attended
- number of booked appointments
- number of unplanned appointments
- categorisation of referrals
- number of iron infusions administered
- number of telephone consultations
- length of Stay

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