Australian Government
Department of Health, Disability and Ageing

Multi-Purpose Service Program (MPSP)

Direct Care Minutes Targets: Trial Guide for 1 October – 31 December 2026

Contents

1. About this guide

This guide supports Multi-Purpose Services (MPS) participating in the next phase of the Direct Care Minute Targets trial from 1 October 2026. This phase will test direct care targets and reporting arrangements across MPS settings.

The guide explains the purpose and objectives of the trial, what MPS will be asked to do, and how reporting will operate during this phase.

Note:

- This guide describes arrangements for the next phase of the trial and will be treated as a living document throughout the trial period.
- It may be updated for 1 January 2027 and beyond to reflect operational experience, provider feedback, implementation issues or matters identified through MPSP Working Group (WG) discussions.
- Any substantive changes will be communicated to participating providers. Updates will be version controlled, tracked and documented.

2. Background

Ensuring older people in residential aged care have access to appropriate levels of direct care is a key part of the Australian Government's aged care reforms. The Commonwealth also needs assurance that these levels of care are being delivered.

In response to Recommendation 86 of the Royal Commission into Aged Care Quality and Safety, care minute requirements were introduced for mainstream residential aged care homes from 1 October 2023. Similar requirements are also now in place for homes that deliver services under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP).

Why the trial is being undertaken

The Australian Government is working towards introducing similar arrangements to support equivalent consumer protections for residents in homes funded under the Multi-Purpose Service Program (MPSP).

However, it has been recognised that as MPS operate under different service, workforce and funding arrangements, a tailored implementation approach is required.

As a result, since 1 July 2024, the Department of Health, Disability and Ageing (the Department) has been working with States and Territories, and MPSP providers, to explore **the best approach to provide assurance that residents in MPS have access to appropriate levels of direct care.**

This 'direct care target trial' has proceeded via a phased approach, which to date has involved co-design and planning (Phase 1) and targeted pilots to inform policy design (Phase 2).

What is the purpose of the trial

The overall aim of the trial is to develop a shared understanding of how direct care is delivered in MPS settings, and to test feasible, proportionate ways to report direct care time in mixed health and aged care environments.

The initial phases explored how direct care targets could be established for the MPSP, how reporting against those targets could operate, and whether any adjustments to mainstream requirements or reporting would be needed before any formal obligations are introduced.

The Department was also keen to explore whether alternative implementation approaches could better reflect thin market settings and MPS workforce structures. However, no feasible alternative approach has been identified to date.

The next phase of the trial, which will commence **on 1 October 2026 is a full trial of direct care target arrangements**. It will test direct care target arrangements based largely on mainstream residential aged care arrangements. However, consistent with the approach used for NATSIFACP, MPS will have a standard target rather than individual care minute targets.

What is this phase of the trial intended to achieve

This phase of the trial is intended to test the:

- whether an initial standard target of 200 care minutes, followed by a higher target of 215 care minutes, is feasible across all MPS in future
- the administrative burden and benefits of different reporting approaches - with reporting expected to be adjusted across the 12-month trial in consultation with States and Territories, and MPSP providers to ensure we get the balance right.

This will then provide baseline data regarding current direct care levels in MPS and inform the likely cost of progressing to full implementation.

The trial is designed to test whether standard direct care targets are achievable across diverse MPS settings and workforce models nationally.

Findings from this phase will inform future decision-making on the direct care trial and any next steps for MPSP direct care arrangements.

Important:

- This remains a **genuine trial period** and forms part of broader MPSP reform work being undertaken by the Department in partnership with jurisdictions.
- The trial will continue to support shared learning and evidence-building.
- Reporting during the trial will not, of itself, result in regulatory or compliance action.
- MPS are not expected to introduce new systems or additional documentation for the purposes of the trial. Nevertheless, providers are encouraged to participate actively, test the proposed arrangements in their local context, and help build a shared understanding of how they would operate in practice.
- Providers should also raise implementation challenges, innovative solutions or new ideas with the Department through State or Territory health representatives.

What else will be progressing in parallel?

The Department will continue to work closely with States and Territories to consider further adjustments to proposed direct care arrangements for MPSP alongside this trial period.

This is expected to include consideration of variability in care delivery across MPS, reported workforce and viability pressures for smaller MPS, and any relevant developments arising from the MPSP Funding Model Review (the Review) – see Section 7 below.

3. What will the next phase involve

Overview and timing

This next phase of the trial (Phase 3) is to commence **from 1 October 2026.**

Following agreement by the MPSP WG, it will proceed via a staged approach as outlined below – starting with an initial 200-minute direct care target, which would then increase to 215 care minutes in 2027.

Stage 1 – 1 October to 31 December 2026
200 minutes of direct care per resident per day
including 40 Registered Nurse (RN) minutes

Stage 2 – 1 January to 30 September 2027
215 minutes of direct care per resident per day including 44 RN minutes

What MPS are being asked to do during the trial

During Stage 1, MPS are to test their ability to meet a standard 200-minute direct care target. They will then simply be asked to:

- report whether the applicable total direct care target was met for each reporting period
- report whether the applicable RN care target was met,
- indicate, at a high level, what information was relied on to support their reporting, and
- provide any additional information that will assist explain the responses.

Section 4 provides more information on the criteria for meeting the target. Section 5 then explains how you can apportion staff time towards direct care for aged care only.

Section 6 provides more information about required reporting and how this information will be collected during Stage 1.

Important:
- For Stage 2, the target period will increase.
- Additional reporting for Stage 2 also remains under consideration in consultation with the States and Territories.

What if I don't meet the target in place at the time

Based on Phase 2 trial results, it is anticipated that many MPS will already meet or exceed these indicative targets under existing workforce arrangements. However, the aim of the next phase of the trial is **to test this assumption**.

As noted above, there are no compliance or enforcement activities associated with the trial. We want to understand without prejudice where other MPS or particular service models will struggle to meet the targets without operational adjustments.

Even where formal implementation of these arrangements does proceed with the agreement of the States and Territories, the Department recognises that, for some MPS, working towards the required target may require adjustments to staffing profiles, skill mix or rostering practices over time.

What additional funding is available to MPS during the trial

All MPS are already being provided with additional funding as part of direct care trial arrangements to support them delivering 200 minutes of direct care per place per day.

This is made available through the Direct care supplement amount (see section 249-30 of the Aged Care Rules 2025), with funding weighted depending on the remoteness of the MPS (based on the Modified Monash Model 2023). This supplement is paid on a per-residential care place, per-day basis. It is not dependent on occupancy consistent with broader MPSP block funding arrangements.

These arrangements will remain in place to cover Stage 1 of this phase of the trial (i.e. up until 31 December 2026).

Important:

- The Australian Government has allocated additional funding to support a future increase to 215 care minutes under the MPSP, subject to implementation arrangements. However, any additional funding from 1 January 2027 requires amendments to the relevant legislative rules.
- The Department acknowledges that workforce costs may vary across MPS settings, including where MPS operate in constrained labour markets or rely on higher-cost staffing models. However, these are matters for consideration under the Review.

4. Direct Care Target Requirements

What does the target apply to

For Stage 1, the target to be met for each residential care home (i.e. your MPS) is 200 minutes of direct care per resident per day including 40 RN minutes.

What activities can be counted towards the target

For Stage 1, only **direct clinical and personal care** delivered to MPS residents by **eligible workers** may be counted and will be reported on – consistent with mainstream residential aged care minutes policy. Care delivered to hospital or health service patients, administrative duties, training, leave and non-direct care activities **are excluded**.

Eligible workers include:

- Registered Nurses (RN)
- Enrolled Nurses (EN)
- Personal Care Workers / Assistants in Nursing (PCW/AIN).

Detailed examples of eligible and excluded activities are provided in **Appendix A.**

What about if staff work across health and aged care functions?

At many MPS nursing and care staff deliver services across residential aged care and health or hospital functions. Instead, you should attribute a proportion of staff time to residential aged care – see Section 5 below.

5. Apportionment and evidence during the trial

What is meant by apportioning staff time?

Apportionment allows an MPS to attribute a proportion of staff time or cost to residential aged care, where staff work across multiple service streams. At an MPS, this may involve where:

- nursing staff covering both health and aged care residents on the same shift
- staff rotate between acute, community and residential care functions
- workforce models do not align neatly to a single service line.

What method do I need to use?

There is no single required method for apportionment during the trial. Appropriate approaches may differ across services depending on workforce arrangements, systems, and scale.

For example, your MPS may already apportion staff time to residential aged care using one or more of the following approaches:

- payroll or cost-centre allocation, where staff hours or costs are recorded against an aged care or service-specific code
- rosters with service allocation, where shifts or portions of shifts are clearly designated as residential aged care

- time-allocation or split-role records, used where staff routinely work across health and aged care functions
- agreed percentage or modelled allocations, supported by rosters, payroll data, or local workforce models
- manager or supervisor attestation, where formal systems do not distinguish service lines, but allocation practices are well understood and consistently applied.

These approaches may be used alone or in combination, depending on what information is available.

Supporting evidence during the trial

The Department expects that where requested an MPS will be able to:

- describe the approach used to attribute staff time to residential aged care
- rely on existing records or accepted local allocation practices
- ensure apportionment is reasonable, explainable, and consistently applied for the reporting period.

That is, you should be able to explain at a high level how staff time was apportioned to residential aged care for the purposes of reporting against the trial targets, using information that is reasonable and available within business-as-usual operations.

For the purposes of the trial, apportionment should be supported by information that allows the service to explain how reported outcomes were derived, rather than to demonstrate absolute accuracy.

Collecting information during the trial and the types of information that may be relied on

To assist providers to report their progress during the trial, they will need to collect information that is available to them from their business-as-usual sources.

While the department is providing reporting templates used for **submitting** a report (Section 6 below), the department is not providing any specific template for providers for collecting information.

Providers are free to collect the necessary information in a manner suitable to them.

Information relied on during the trial should:

- relate to the relevant reporting period
- draw on routine, contemporaneous records where these exist
- not require reconstruction of historical data

MPS are **not** expected to:

- introduce new payroll, rostering or time-tracking systems
- undertake minute-by-minute activity tracking
- retrospectively reconstruct historic staff time
- achieve precision beyond what is reasonable in a mixed-service environment.

Supporting information may include:

- rosters or payroll summaries showing staff hours
- payroll or cost-centre records
- timesheets or allocation records for staff working across services
- workforce or clinical systems that record staff activity
- documentation that explains the allocation method used
- local workforce models or agreed conventions for mixed roles.
- time-in-motion or structured sampling studies (where used).

Note: Care documentation (such as progress notes or clinical records) may help to confirm that staff were delivering eligible direct care activities but is not used to calculate care minutes or undertake apportionment.

6. Reporting arrangements

How reporting will occur

To provide flexibility for providers, one of two approaches outlined below can be used.

Questions and responses are identical regardless of the preferred approach. Both require provider level endorsement by an appropriate person within the provider entity.

Regardless of the approach selected, **one report is to be completed for each MPS** (i.e. not for individual buildings or parts of the MPS).

- **Approach 1: Reporting through the web-based platform Qualtrics.**
  - Each provider nominating this approach will receive a unique link for each of their MPS ahead of the reporting period (January 2027). There is no requirement to create an account or provide personal details
  - This approach can be used to report a single or multiple MPS, but providers must complete a separate report for each MPS.
  - The separate provider level endorsement template must be uploaded to Qualtrics; together with the optional Care Minutes Calculator Tool where used (see below).
- **Approach 2: Reporting using emailed Excel based spreadsheet.**
  - Two versions of the spreadsheet will be available to cater for providers reporting for a single or multiple MPS.
  - This approach will enable providers reporting for multiple MPS to submit all their reports in the one file by email.
  - The separate provider level endorsement template must also be returned by email; together with the optional Care Minutes Calculator Tool where used (see below).

The department will ask providers to **nominate their preferred approach** (**Option 1 or 2) during September-October 2026** – ready for them to complete their Stage 1 report in January 2027.

What information is reported

The specific reporting requirements for Stage 1 of the trial are set out within **Appendix B** to this Guide.

MPS will be asked to answer and provide information to **3 key questions** within one **required** report:

- whether the total direct care target was met
- whether the RN care target was met
- what type of information was relied on to support the reporting.

Where a target is not met, MPS will be asked to provide an indicative estimate of the minutes delivered to assist trial learning. No documentation upload is required.

Providers will also have the **option** of submitting one additional report: **the Care Minutes Calculator Tool (CMC Tool).**

More information about the CMC Tool is set out within **Appendix B** below.

When will we need to report (based on Stage 1 arrangements)

Reporting is to be submitted quarterly and includes 3 months of data:

- **October – December 2026 (reported January 2027)**
- January – March 2027 (reported April 2027)
- April – June 2027 (reported July 2027)
- July – September 2027 (reported October 2027)

What information may support trial reporting

Reporting is intended to be proportionate and appropriate for the MPS setting and based on information services already hold or reasonably rely on in the normal course of business.

Information relied on during the trial should, where reasonable:

- be MPS-specific
- be traceable to routine records where these exist
- be reasonable and defensible for the purpose of explaining reported figures

Estimates provided may be based on reasonable business-as-usual information.

How will collected data be handled

Information collected through the provider's preferred reporting approach will be:

- aggregated and de-identified for analysis
- used to inform evaluation of the trial and future policy considerations
- shared externally (where relevant) only at regional or jurisdictional level.

No MPS-level performance data will be published.

7. Next steps

Preparation for Stage 2 of the trial

Alongside Stage 1 of the trial, the Department will work with jurisdictions and providers to confirm any adjustments to trial arrangements before Stage 2 commences and/or for subsequent reporting periods.

Monitoring and reporting of further trial outcomes

As previously, trial outcomes will be analysed, summarised and discussed with jurisdictions through the reforms sub-working group and the MPSP WG Findings and further recommendations for adjustments will also then be shared and discussed with providers at ongoing MPSP reform webinars.

Consistent with the purpose of **this phase of the trial** – analysis will focus on:

- feasibility of proposed standard care minute targets, including variation across different MPS service models, and
- understanding the value, appropriateness, feasibility and administrative burden of proposed reporting in MPS settings.

Further policy design and transition to formal obligations

The Department will also continue to work with jurisdictions to determine the next steps in terms of evaluating the overall outcomes of the phased direct care trial to inform further MPSP WG discussions around transition to formal obligations.

It is noted that separate work packages undertaken in parallel may also inform these discussions and agreement through the MPSP WG, including as part of ongoing work through the Review and/or broader aged care reform work.

As discussed with States and Territories, further work is also being considered, alongside this Review, to understand how future funding arrangements and direct care arrangements can be utilised to drive improved resident outcomes and the delivery of high quality care in an integrated health and aged care service environment.

8. Further information and support

For further information, visit the MPSP website or contact mpsagedcare@health.gov.au.

Appendix A – What is direct care?

Direct care refers to clinical and personal care activities delivered directly to aged care clients of residential aged care services.

This includes hands-on care, monitoring, assessment and assistance with activities of daily living that align with mainstream residential aged care minutes policy.

Direct care **includes, but is not limited** to:

- clinical assessment and monitoring
- medication management
- wound and pressure injury care
- assistance with mobility, eating, hygiene and continence
- behavioural and cognitive support provided one-on-one
- direct nursing and personal care interactions with residents.

Direct care **does** not include:

- administrative or managerial duties
- training or education activities
- meetings (including clinical handover)
- break times
- leave or non-worked time
- indirect care activities
- care delivered to non-aged care patients

Appendix B – Reporting for Stage 1

Reporting Template (both Qualtrics and Excel)

Question 1 – Total direct care target
During this reporting period, did your MPS meet the applicable total direct care target per resident per day?

□ Yes
□ No

Question 1a – Indicative total care minutes delivered
(Displayed only if "No" is selected above)

If the total direct care target was not met, approximately how many *total care minutes per resident per day* do you estimate were delivered during this reporting period?

[ ] Numeric field (estimate)

Note: *This question is intended to provide context for trial learning.*
Precise calculations or supporting documentation are not required.

Question 2 – Registered Nurse (RN) care target
During this reporting period, did your MPS meet the applicable *RN care* target per resident per day?

□ Yes
□ No

Question 2a – Indicative RN care minutes delivered
(Displayed only if "No" is selected above)
If the RN care target was not met, approximately how many *RN care minutes per resident per day* do you estimate were delivered during this reporting period?

[ ] Numeric field (estimate)

Note: *This question is intended to provide context for trial learning.*
Precise calculations or supporting documentation are not required.

Question 3 – Information relied on to support reporting
What type(s) of information did your MPS rely on to support the reporting above?
(Select one or more of the types of information below)

- Rosters or staffing allocations
- Payroll or pay records
- Timesheets or staff time-allocation records
- Workforce, rostering or clinical systems
- Aggregated summaries supported by routine records
- Time-in-motion or structured sampling study
- Other business-as-usual information

Formal evidence is not required to be submitted with the report.

Question 3a – Please briefly describe the "Other business-as-usual information" used.
(Displayed only if 'Other business-as-usual information was selected at Q3. Free text response.)

Question 3b – Of the information types selected, which do you prefer most?
Please select the most preferred or most relied on type of information.

Question 4 – Please provide any additional information to help explain your responses.
Please include information that is relevant to meeting or not meeting the direct care targets and the factors that contributed for example, pros/cons of preferred information types or local service arrangements, workforce constraints, mixed-service approaches or the labour types that comprise the reported outcomes.
Free text response.

Question 5 – Enter the estimated total time to complete this report.
The time taken to complete this report includes the time taken to access the information or records indicating the amount of direct care minutes and whether the targets were met'.

Do not include the time taken to complete the optional Care Minutes Calculator Tool

[ ] (minutes)

Question 6 – Do you intend to submit a completed optional Care Minutes Calculator Tool?

- If **No**:
  - **If reporting in Qualtrics**, proceed to the submitter details section and upload the signed Endorsement document, **or**
  - **If reporting in Excel**, tick the Endorsement checkbox to confirm that the signed Endorsement document will be emailed to MPSAgedCare@health.gov.au.
  - Review the Completion Check section and ensure all required fields show as complete and the Overall Status displays **Ready to submit**.
  - Save the completed Excel report file (see table below for file naming convention).
- **If Yes - Question 6a:**
  - **If reporting in Qualtrics,** upload the completed Calculator Tool.
  - **If reporting in Excel,** tick Question 6a to confirm that the completed Care Minutes Calculator Tool will be emailed to MPSAgedCare@health.gov.au with the completed reporting template.
- **Question 6b:** Enter the estimated time to complete the Calculator Tool.
  Note that the time taken to complete the Calculator Tool includes the time taken to access the necessary information or records and enter within the Tool.

[ ] (minutes)

Endorsement

For both the Qualtrics and the Excel spreadsheet approach, one provider level endorsement covering all their MPS is required to be returned with the completed report(s).

Submitting reports: File naming conventions

When submitting your reports please used the following file naming conventions.

Document/File	Qualtrics Reporting	Excel Reporting	Filename Convention
Stage 1 DCM Report Template (required)	N/A – completed online	Email completed template to MPSAgedCare@health.gov.au	**Single MPS report**: MPSP Stage 1 DCM Trial <**Provider Name**> Single MPS Report.xlsx **Multi MPS report**: MPSP Stage 1 DCM Trial <**Provider Name**> Multi MPS Report.xlsx
Provider Endorsement (required)	Upload to Qualtrics.	Email with the reporting template.	MPSP Stage 1 DCM Trial Endorsement <**Provider Name**>.pdf
Care Minutes Calculator Tool (optional)	Upload to Qualtrics	Email with the reporting template (optional only)	MPSP Stage 1 DCM Trial Calculator Tool <**Provider Name**> <**MPS Name**>.xlsx

Note: Replace < Provider Name >, <MPS Name> with the relevant details. Remove or replace special characters that are not permitted in filenames (<,>).

Optional reporting: Care Minutes Calculator Tool

MPSP providers will also have the **option** of providing an additional report by completing the **Care Minutes Calculator Tool (Calculator Tool)**.

What is the Calculator Tool?
The Calculator Tool is a separate Excel based file that can be used to report for a single MPS. Starting with the information the MPS uses to determine care workforce time (see examples in Appendix C), the Tool can be used to calculate both overall direct care minutes and RN direct care minutes per aged care resident per day

How should we count hours?
There is no single required way to count care workforce time (hours). MPS may choose an approach that best reflects how their data is held, provided it is reasonable and applied consistently within the month. The department does not require services to count hours at an individual staff member or shift level, provided the overall estimate is reasonable and supported by routine records.

Using the Tool involves a small number of simple steps including:

- entering the average number of aged care residents for the reporting period
- selecting the role or roles delivering care (e.g. RN, EN, PCW, AIN, Student Nurse)
- entering the total number of hours for care staff across the MPS for the reporting period
- apportioning the total hours that were attributable to aged care (percentage)
- apportioning the aged care hours that were direct care (percentage)

The Tool will calculate and compare the result to both the applicable total direct care target and the RN target.

Providers with multiple MPS
Providers with multiple MPS who are wanting to use the Tool to report for each MPS can elect to do one of the following:

- complete one separate Tool per MPS, returning each file back to the department
- add a new tab to the Tool file for each MPS the provider is reporting for
- request that the department email to the provider, one Calculator Tool file with a tab of each of the provider's MPS (email: MPSAgedCare@health.gov.au).

Downloading the Calculator Tool and further information
Providers considering or intending to use the Calculator Tool can download a copy from the department's MPSP Direct Care Trial web page from October 2026. Additional guidance for using the tool will also be available from the website.

Submitting a completed Calculator Tool
For Stage 1 of the trial, as for the completed DCM report template, a completed Calculator Tool can be submitted to the department in January 2027. This is **not** a substitute for the **required** DCM Report Template.

Appendix C: Types of Information - illustrative options

The table below provides illustrative examples only of information an MPS may already use, or may reasonably rely on, to help explain how direct care time was derived during the trial.

MPS are not expected to use all options listed, nor to introduce new systems or documentation for the purposes of the trial. The appropriate approach will depend on the size of your MPS, workforce model and existing systems.

These categories are intended to assist understanding only. They are not a checklist and are not intended to prescribe a single approach.

Evidence example	Classification	What it helps demonstrate	Notes
Payroll or pay records with MPS or cost-centre allocation	Primary	Actual paid hours worked by eligible staff and attribution to residential aged care	Strongest form of primary information where available; aligns with mainstream care minutes practice
Rosters with explicit MPS allocation	Primary	Planned and delivered staff time allocated to aged care	Where rosters do not distinguish aged care from health functions, additional explanation may be needed
Timesheets or time-allocation records	Primary	Allocation of staff time where staff work across health and aged care services	Does not require minute-by-minute tracking
Electronic workforce, rostering or clinical systems	Primary	Staff hours or activity recorded against aged care beds and clients, or service units	Acceptable where data can be extracted or summarised
Shift-level declarations or supervisor attestations	Primary	Confirmation that a shift or portion of a shift was delivered to residential aged care	Useful where formal systems are limited; should align with routine practice
Aggregated allocation summaries supported by source data	Primary	Total staff hours allocated to aged care over a reporting period	Underlying source records (e.g. rosters or payroll) should be retained
Time-in-motion or structured sampling studies	Primary (supplementary)	Estimated proportion of staff time spent on direct care in aged care	Optional; particularly useful in complex, integrated service models
Care documentation (progress notes, care task records)	Supporting	Nature of work performed and confirmation that staff time relates to direct care	Used to corroborate primary information; not used to calculate minutes
Role or position descriptions	Supporting	Eligibility of staff roles to be counted toward direct care minutes	Supports role eligibility, not hours worked
Staffing models or establishment profiles	Contextual	Intended workforce mix and coverage	Provides context only; not evidence of hours worked
Workforce or service delivery models	Contextual	How services are structured across health and aged care functions	May assist explanation when considered with primary information