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Implementing a publicly funded homebirth program

Guidance for Queensland Hospital and Health Services

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Implementing a publicly funded homebirth program – Guidance for Queensland Hospitals and Health Services

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An electronic version of this document is available at https://www.health.qld.gov.au/system-governance/policies-standards/guidelines

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Statement

Having a baby at home through the public hospital system is now an option in almost all states and territories in Australia.[1] There is strong evidence that for selected women, when homebirth is well-integrated into the health service, it is beneficial and safe for mothers and babies.[2]

In Queensland, the percentage of women choosing to have a homebirth has increased from 0.09 per cent in 2011 to 0.5 per cent in 2020.[3] In recent years an indication for local demand can be derived through a 30% increase experienced by private practice midwives in Queensland over the last 2 years.

As publicly funded homebirth is a new service in Queensland, some direction and guidance for boards of Hospital and Health Services (HHSs), health service executives and clinicians are required. This will assist in assessing the appropriateness of the model for the local context and to clarify the requirements for a safe, high quality and sustainable program.

The safe operation of a homebirth program is a key consideration and as such it has been determined that to consider establishing a homebirth program, health services must be providing, as a minimum, maternity services consistent with Queensland Health Maternity Services Clinical Skills Capability Framework 3.2. Complexity of care for a Level 3 service includes the management of normal risk pregnancies, including the management of labour, birth and puerperium at 37 weeks gestation or more including elective and emergency caesarean section capability.

To inform this implementation guide, broad consultation has occurred and includes evidence derived from international and national research, alongside benchmarking with other Australian states and territories. A systematic review of homebirth research, and a synthesis of publicly funded homebirth guidelines from other Australian jurisdictions were undertaken providing reassurance of safety. Engagement, input, and advice were sought from content experts, system leaders and external stakeholders, including through the establishment of a Homebirth Advisory Committee. Such operational, clinical and corporate knowledge and experience has been captured and blended with the relevant evidence and other useful resources to form this guide.

At present there is no high level evidence from randomised controlled trials to assess the overall relative risks or benefits of homebirth versus hospital birth for low risk women. Therefore, the advice in this guide is drawn from large cohort studies and from evaluations of the publicly funded homebirth programs currently operating in Australia.

In high-income countries, for selected women at low risk of perinatal complications, planned homebirth at onset of labour is associated with:

- Similar or better outcomes for mothers and babies[4-7]
- Higher levels of childbirth satisfaction[8]
- Reduced healthcare costs[9,10]
- Less iatrogenic events related to overuse of medical interventions[4,6,7]

Both the Australian College of Midwives (ACM)[11] and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)[12] support women's right to make an informed choice about place of birth. Publicly funded homebirth is provided by midwives employed by the health service, usually working within midwifery group practice providing caseload care.[13] Well-designed publicly funded homebirth programs, incorporating evidence-based practices and procedures, can provide a safe birthing option for low-risk women in Australia.[14]

Whether a homebirth program is part of the maternity service at a public health service is ultimately a decision for the HHS board and executive team and will be informed by the views of the community and the workforce. This guide aims to assist HHS boards to do their due diligence and provides a framework to plan, deliver and monitor a publicly funded homebirth program.

Queensland Health is committed to providing women with more choice and access to a range of safe maternity service models. This includes a homebirth stream that provides women - at low risk of pregnancy or birth complications - an option to have a planned birth at home under the care of public hospital midwives. This guideline clearly defines steps required prior to commencing a publicly funded homebirth model.

Scope

This policy applies to all employees, contractors and consultants within the Department of Health divisions and Hospital and Health services (HHSs).

Implementing a publicly funded homebirth program: guidance for Queensland Hospital and Health Services provides information and resources to assist Queensland HHSs interested in establishing a homebirth program.

For the purposes of this guide, the term HHS is taken to mean public Hospitals and Health Services providing, at a minimum, Level 3 care as described in the Queensland Health Maternity Services Clinical Skills Capability Framework 3.2. The term 'publicly funded homebirth' is defined as a planned event where a woman with a low risk pregnancy chooses to have a vaginal birth at home under the care of public hospital midwives. It does not apply to women planning a homebirth under the care of privately practicing midwives or to public patients having unplanned homebirths.

In Queensland, HHSs are independent statutory entities and are responsible for ensuring that the care provided to all patients is safe, high quality and within the capability of the service. For HHSs providing maternity care, this includes decisions related to the settings and models of maternity care offered such as homebirth programs.

Homebirth refers to:

- women who meet established or recommended low risk clinical criteria

- women who plan to give birth in their own home at onset of labour
- women that are attended by two registered health practitioners (usually midwives) who have required knowledge and skill in maternal and neonatal emergency and resuscitation.

Homebirth does not include:

- birth without a registered midwife (‘freebirth’)
- unplanned out-of-hospital birth (‘born before arrival’)
- birth at home by women who have not received maternity care
- birth at home by women who do not meet established or recommended low risk clinical criteria.

The guidance outlines considerations for health services in four key sections:

1. Assessing the feasibility of a home birth program
2. Planning a home birth program
3. Providing a home birth program
4. Data, reporting and monitoring a home birth program.

Each section includes principles and guidance information and where possible, further resources. The guidance is based on the knowledge and experience of Safer Care Victoria, and we acknowledge their valuable work informing this guide.

The appendix included is:

1. Organisational readiness checklist

This guide should be used in conjunction with the Queensland Clinical Guidelines *Publicly funded home births guideline.*

Future revisions to this guide will incorporate new information as existing and new publicly funded homebirth programs are introduced and grow over time.

Requirements

1. Principles

The guidance for health services outlined in this document is based on the Right to health services – Section 37 of the Human Rights Act 2019 and the following principles for publicly funded homebirth programs.

Principle 1

A homebirth program is established where the HHS has the capacity and capability to provide a safe, high quality, and sustainable program and where a robust feasibility and planning process has been undertaken.

Principle 2

HHSs considering a homebirth program lead effective and open consultation, engagement and communication within their organisation and with the local community, key service partners and other healthcare providers.

Principle 3

A homebirth program is integrated into the HHSs maternity service and appropriately resourced to provide high quality and safe care in a community context.

Principle 4

The eligibility of women for a homebirth program is determined by HHSs in collaboration with the community and is informed by evidence- based clinical guidelines, individualised risk assessments and the capacity and capability of the organisation.

Principle 5

A homebirth program is woman-centred, and women are supported to make informed decisions about their own care and the care of their baby.

Principle 6

A safe and high-quality homebirth program is informed by data to drive service improvements and is evaluated regularly to ensure it is high performing and responsive to the needs of the community and key partners.

2. Requirements

Assessing the feasibility of a homebirth program

HHSs, particularly the boards of HHSs, are responsible for deciding if a HHS will provide a publicly funded homebirth program and for ensuring that the program delivery and operation is consistent with relevant legislation and government policies. The decision to implement a homebirth program and the success of a program will be dependent on a range of organisational and contextual factors. Prior to any planning, HHS executives and boards will need to consider the feasibility of implementing a publicly funded homebirth program.

To consider establishing a homebirth program, HHSs must be providing, as a minimum, maternity services consistent with Level 3 care as described in the *Queensland Health Maternity Services Clinical*

Skills Capability Framework 3.2 (Dec 2014). This level of care comprises the management of normal risk pregnancies including the management of labour, birth and puerperium at 37 weeks gestation or more including elective and emergency caesarean section capability.

Midwifery group practice caseload care (MGP) is the recommended model of care for homebirth programs as it facilitates a strong relationship between the woman and her midwife/midwifery group. Multidisciplinary team case conferencing as per usual MGP case management should be maintained.

Feasibility assessment

Feasibility assessments, particularly for small maternity services, are critical to ensure that the decision making distinguishes between service feasibility and sustainability.

The purpose of the feasibility assessment is to ensure that on balance there is a reasonable probability that the program will be successful and sustainable. After receiving the feasibility assessment, the board or executive may require further investigation or exploration of issues to be able to plan a decision. HHSs are encouraged to utilise the *Maternity Services-Decision Making Framework*.

A formal feasibility assessment is a critical preliminary step to ensure responsible and accountable governance. The service planning parameters that may be part of a feasibility assessment include:

- Key organisational factors such as the capability level and capacity of the maternity service.
- Current range of maternity service models and experience with caseload midwifery group practice. Caseload midwifery describes a model in which a 'primary' midwife and a 'back-up' midwife take care of a woman during pregnancy, labour, birth and in the postnatal period
- Workforce profile including staff interest in homebirth and skills
- The proximity, capacity and capability level of other maternity service providers in the local region
- Birthing activity trends and population projections of the target low risk cohort
- Local community interest in a publicly funded homebirth program inclusive of the support of maternity consumer representatives
- Anticipated revenue and costs associated with the operating requirements of the program
- Impact on other clinical services including existing maternity services

A robust assessment of the feasibility of establishing a homebirth program will support the board to decide if it is appropriate to undertake further planning at that time. Not all HHSs will be able to offer publicly funded homebirth and there is no single service model that will work for every health service.

HHSs may wish to audit their maternity records to assess the number of women birthing at their service who may be suitable for a homebirth against a range of clinical parameters included in the Queensland Clinical Guidelines *Publicly funded homebirth guideline*. When establishing or extending midwifery group practice with homebirth as a service offering, it is recommended HHSs use the Clinical Excellence Queensland *Maternity Decision Making Framework.*

An independent assessment or input into the feasibility assessment may also be beneficial to provide balanced advice to the organisation. HHSs should undertake their own review of evidence related to

homebirth and consider position statements on homebirth from key colleges such as the Australian College of Midwives[11] and Royal Australian and New Zealand College of Obstetricians and Gynaecologists.[12] HHSs are advised to document the findings of their feasibility assessment for future reference.

If the assessment recommends not to implement a program, the HHS should consider communicating to the organisation and the community the general process used to determine the feasibility and what conditions would need to be met to revisit that decision in future given the evidence for enhanced outcomes and increasing demand. Human rights issues should also be considered.

The service may wish to engage with other maternity services who are implementing a homebirth program and maternity consumer groups to seek opportunities to work collaboratively to provide a safe, high quality and sustainable program for the local community.

Capability level

To consider establishing a homebirth program, it is mandatory that HHSs are providing, as a minimum, maternity services consistent with Level 3 care as described in the Queensland Health *Maternity Services Clinical Skills Capability Framework 3.2* (Dec 2014). This requirement is so that timely access to emergency caesarean section for women having a homebirth can be provided without the need for a secondary transfer.

Maternity models

Maternity models of care in the *Model of Care National Best Practice Data* are grouped into 11 model categories however there is no single accepted model for homebirth service delivery.[15] The Victorian model that this guide is based on utilised midwifery group practice caseload care and consider this relationship to be central to providing a safe and effective homebirth program. It is therefore important that the health service has experience in operating a sustainable caseload midwifery model before expanding their maternity program to include homebirth.

Sustainability and smaller services

Sustainability of maternity services is a particular issue for rural and other small health services. Ceasing service models that have become unviable is challenging for staff and the local community. Feasibility assessments for small maternity services are critical to ensure that the decision making distinguishes between service feasibility and sustainability. HHSs should consider the volume of pregnant women and their risk profile in their current maternity models and whether there is sufficient demand to support a new program or an extension of existing MGP models without impacting viability.

Further resources:
https://www.health.qld.gov.au/__data/assets/pdf_file/0024/444273/cscf-maternity.pdf
https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/service-delivery/cscf
https://content.health.vic.gov.au/sites/default/files/migrated/files/collections/policies-and-guidelines/i/implementing-a-public-home-birth-program.pdf
https://qheps.health.qld.gov.au/nmoq/maternity/models-of-care-toolkit/strategy/evidence-base

https://www.qhrc.qld.gov.au/your-rights/human-rights-law/right-to-health-services

3. Planning a homebirth program

Planning a homebirth program can commence following a decision by the board of the HHS that a HHS has the capacity and capability to provide a safe, high quality and sustainable program.

When developing guidelines, HHSs should:

- seek independent legal, financial and industrial advice.
- assess service capacity and capability, in the context of clinical and financial risk, prior to establishing a home birth program.
- consult with their community, maternity consumers and key partners during the planning phase for a home birth program.
- determine eligibility criteria in conjunction with subject matter experts and consumers which are relevant to their local service and are responsible for deciding which women are clinically safe to enter their home birth program.
- develop clinical pathways for the home birth program to support care in the antenatal, intrapartum and postnatal care periods including processes for consultation, escalation or referral when required.
- ensure all staff providing home birth services have suitable confidence and competence to deliver high-quality and safe services in the home setting.
- ensure the health and safety of staff providing care in the home setting.

Implementation guidance

After determining and assigning the project management resources, the following steps should guide the planning phase:

- Assess internal support and engagement
- Assess community/maternity consumer interest and expectations
- Assess support from key partners
- Establish governance arrangements
- Assess organisational capability and capacity
- Develop the service model (eligibility criteria, local industrial agreements and clinical pathways)
- Identify program resources and budget
- Develop a communication and engagement strategy.

Assess internal support and engagement

HHSs should assess the level of support for establishing a home birth program from staff, the community and key partners. In particular, consultation with the local workforce will assist in ascertaining the local circumstances that will impact on the program establishment. Key staff to engage include:

- the chief executive officer and executive management team
- relevant program directors, for example women's and children's services neonatology and

midwifery
- medical staff such as directors of services, consultant obstetricians, senior obstetric registrars, paediatricians, neonatologists, anaesthetists and emergency staff
- nursing and midwifery staff such as unit managers and midwives across maternity and neonatal services
- support services such as pathology and pharmacy.

Collaborative midwifery and medical leadership is an important factor in any HHSs decision to provide a home birth program and particularly from senior clinical and executive staff across service areas that would be involved in the program.

Appendix 1 provides a checklist to assist HHSs in assessing their organisation's interest and readiness to develop a home birth program.

Assess community interest and expectations

HHSs should consult with women and families in the community to determine local interest in, and the likely level of demand for a home birth program. This can be undertaken in an informal way (for example, seeking input from women at antenatal appointments) or formally (for example, undertaking a survey or scheduling community consultations).

Central to the success of a home birth program is ensuring expectations align with what can reasonably be provided. The expectations of women, their families and the wider community as well as health professionals and other key partners should be considered. How women's expectations of a service compare with their experiences may influence their satisfaction with the service. Discussions about the service model and eligibility for a home birth program should be included in any consultation with community.

Assess support from key partners

HHSs are advised to consult with key partners to discuss the likely involvement and level of support from these organisations for a home birth program. It is recommended that Queensland Ambulance Service is consulted early in the planning stage.

HHSs should also consult with other local health service providers (non-Government organisations, Aboriginal Community Controlled Organisations) who may receive transfers as well as local maternity care providers such as General Practitioners or Obstetricians and Maternal and Child Health providers.

Establish governance arrangements

The home birth program should not be considered as an additional maternity service but is an extension of the existing Midwifery Group Practice (MGP) model within a HHS. This ensures it remains integrated within the existing HHS governance arrangements.

HHSs are encouraged to form a multidisciplinary steering committee to oversee the development, implementation and evaluation of the home birth program. This approach will strengthen the HHSs

governance of the program and its ability to provide safe, high quality maternity care to women who are eligible and choose to have a home birth. The composition of a steering committee is up to individual HHSs. HHSs may also consider inviting representatives from other key stakeholder groups such as consumer groups and professional colleges and unions.

Clinical governance

Clinical governance is where managers and clinicians share responsibility and are accountable for patient care, minimising risks, and for continuously monitoring and improving the quality of care. For Queensland HHSs, compliance with the clinical governance policy framework is mandated.

Any risks that may be associated specifically with a home birth program should be managed within the HHSs established clinical risk management systems and processes that support and promote the safety and quality of care.

In addition to the existing strategies for minimising risk in maternity services, HHSs should consider the following approaches to minimising potential risks associated with a home birth program:

- Establishing good governance including a multi-disciplinary steering committee to oversee the development, establishment and evaluation of the home birth program.
- Setting clear eligibility criteria for the program.
- Developing guidelines to determine when women should be transferred to hospital-based care.
- Enabling midwives who provide the home birth program to also work in hospital-based maternity services to maintain skills and relationships with in-hospital staff.
- Ensuring the provision of appropriate equipment to care for women in their homes.
- Ensuring that the equipment in the home birth kit is consistent with that used in the HHSs hospital- based maternity services.
- Ensuring that midwives visit a woman's home prior to birth to assess its suitability for a home birth.
- Ensuring that the birth is attended by two midwives.
- Having processes and mechanisms in place to ensure quality, safe communication occurs during and around the intra-partum period between midwives providing the home birth program and with in-hospital staff.
- Conducting debriefs after every transfer and adverse event.
- Example: Pilot site's steering committee membership:
    - Director of Obstetrics & Gynaecology Director Midwifery Operations Director
    - Midwifery Coordinator Caseload Midwife Quality Manager Project Officer Midwifery Unit Manager Consultant Obstetrician
    - Consumer Representative
    - Queensland Ambulance Service
    - Queensland Nurses and Midwives Union (QNMU) representation
    - Australian College of Midwives (ACM) representation
    - Representation from Aboriginal Community Controlled Health Organisation/s (ACCHO) or Non-Government Organisation (NGO)

The following key documents should support the program's operation and be regularly reviewed:

- Information sheets for women and General Practitioners about the program and informed consent
- Self-assessment eligibility checklist for women
- A home birth policy and procedure manual for staff which includes protocols on:
  - eligibility criteria
  - admission to the home birth program
  - pregnancy care, referral and transfer
  - labour and birth care, referral and transfer
  - postnatal care, referral and transfer
  - home birth emergency transfer
  - refusal to consent
  - communication processes.

Assess organisational capability and capacity

The feasibility assessment may have highlighted areas where work needs to be done to enhance the organisation's capability or capacity to support a home birth program. Depending on the context, timing commencement of a home birth program may be contingent on the rectification of an issue (for example insufficient staff with required skills).

The areas of organisational capability and capacity that are relevant to establishing a home birth program include:

- the current maternity service capability level and sustainability of the service
- the maturity of the clinical leadership approach and clinical governance
- a strong safety culture
- experience at delivering home-based services
- experience and success at the delivery of sustainable midwifery models
- the quality of the relationships between the disciplines and interdisciplinary care
- positive community engagement and relationship management.

Develop the service model

The key activities to develop the service model include agreeing on the eligibility criteria, ensuring local industrial arrangements (Queensland Health) Award – State 2015 s3.3) for MGP (as described below) and developing the clinical pathways and supporting guidance (which are covered in Section 4: Providing a home birth program).

Eligibility criteria for a home birth program

A central part of any publicly funded home birth program is the eligibility criteria. Publicly funded home birth programs target women at low risk for complications, however there are differing views about risk. HHSs must develop eligibility criteria that are appropriate for their context as they are accountable for determining which women are clinically safe to enter their home birth program. Clinical risk must be assessed on an individual basis with each woman understanding that there may be factors in addition to the eligibility criteria that will form part of a clinician's assessment of a woman's eligibility for a program. Eligibility should also be considered in light of emerging evidence.

In line with good risk management principles, health services are encouraged to start the new service with a conservative approach to eligibility and may consider broadening criteria after a period of time when the experience and outcomes can be reviewed and assessed against demand and available resources.

HHSs are advised to engage with relevant midwifery and medical staff during the development of the eligibility criteria to ensure that there is consensus amongst staff on who is safe to enter the home birth program. This will enable the eligibility criteria to be consistently communicated to women and applied in the same way by staff working in the home birth program.

Throughout all stages of pregnancy a woman should be provided with quality and consistent information and education about the benefits and risks to enable informed decision making. Complications or factors arising during a woman's pregnancy that may affect her eligibility for a homebirth should be discussed with the woman and any decisions relating to a woman's eligibility for a homebirth should be made by her in consultation with her care team. Options should be provided in line with Queensland Health's for when women are Declining Recommended Maternity Care.

HHSs must maintain comprehensive records of all discussions and decisions relating to a woman's care and eligibility status. The decision to transfer a woman out of the homebirth program should be clearly documented. Records of communication are important for HHSs and women and, where appropriate, should be provided to other relevant care providers such as General Practitioners as per the Australian Commission on Safety and Quality in Health Care Communicating for Safety Standard.

In any homebirth program, it will be necessary for a proportion of women to be transferred to hospital-based maternity care. This may occur for a variety of reasons during the antenatal, intrapartum or postpartum periods. For a woman who is transferred to a hospital-based maternity service model, HHSs should consider ways to maintain continuity of care, such as the woman having the same primary midwife, if this is her preference. It is recommended that health services establish a process for reviewing decisions that result in the transfer of a woman from the homebirth program to a hospital-based maternity service model.

Staffing models

Caseload midwifery is recommended as the most efficient staffing model for a homebirth program. It facilitates a strong relationship between the woman and her midwife/s.

Other issues to consider in relation to the staffing model are:

- Whether to establish the program within the existing midwifery workforce or recruit new/additional staff. There are advantages and disadvantages to both options. Midwives currently working in the HHS will have the knowledge and experience of the HHSs maternity services but may need additional training to be confident in providing homebirth services. New staff, for example midwives who are currently working in private practice may be experienced in providing homebirth care but will require additional training in health service procedures and

guidelines.
- Ensuring ‘back-up’ systems are in place to manage midwife fatigue and availability.
- The degree of staff cross-over between homebirth and hospital-based maternity services.

Staff training and competence

The delivery of antenatal, intrapartum, and postnatal care in the home setting requires staff with a mix of skills and competencies to ensure that the care provided is of the highest standard. The setting itself may require adaptation of usual practices, procedures and policies from those used in the hospital setting. Therefore, the range of competencies and skills required by a midwife within the homebirth program may vary from a similar role in the hospital setting and may be different from those required in hospital-based maternity services.

HHSs should ensure that midwives are well informed of their obligations for providing care during the homebirth that is consistent with the national professional standards for midwives and is within the scope and boundaries of clinical practice guidelines. To ensure midwives have suitable competence and skills to deliver high- quality, safe services in the home setting, HHSs should:

- develop position descriptions to define responsibilities, accountabilities and activities of midwives delivering care in the home setting.
- appoint/recruit staff with the appropriate skills and competencies to reflect the autonomy of providing care in the home setting.
- clearly define and communicate to staff their scope of practice and limitations of care relevant to the homebirth program.
- tailor staff training and competencies to the home setting.
- consider any additional requirements for peer review and supervision to ensure the skills and competencies of midwives working in the home setting are maintained.

To understand the initial training needs of staff providing care in the home setting, HHSs may need to undertake a skills gap analysis. The evaluation of the Victorian program identified that midwives and doctors agreed that homebirth midwives benefit from extra training including advanced neonatal resuscitation, insertion of intravenous cannulas and perineal suturing skills. Midwives also noted the need for additional communication and negotiation skills.[16]

Caseload midwives should provide care for both homebirthing and non-homebirthing women. This ensures that the midwives are known and familiar to the broader maternity team and environment and prevents staff in the homebirth program from becoming isolated. It also ensures midwives providing homebirth care are abreast of the full scope of the health service’s maternity service and are well placed to support a woman who may need to transfer to hospital-based care at any point in her antenatal or intrapartum care.

Identify program resources and budget

As with other publicly funded maternity program activity, homebirth services are delivered within the existing acute care funding streams. A homebirth program budget needs to account for both costs and revenue for the antenatal, intrapartum and postnatal periods as well as any establishment costs. After

initial start-up costs, a recent study undertaken within the Queensland context indicates that a considerable amount of inpatient health care costs around birth could be saved if 5% of women utilised a publicly funded homebirth program.[17]

Potential establishment costs for health services to consider

The following start-up costs should be anticipated:

- Project management.
- Initial staff orientation, education and training. For example, ensuring various clinicians within the health service are aware of the program and that staff working in the program are appropriately trained in areas such as clinical pathways, documentation and emergency scenarios.
- Communication and engagement activities.
- Equipment (clinical, logistic and communications) – refer to the section below on 'Specific equipment and technology'.
- Suitability assessment and equipment for a home-based service.

Operational costs for health services to consider

Homebirth programs require different costings arrangements to ward-based models and HHSs will need to consider the following:

- Annualised salaries for staff to meet the continuity care of women in this program and provision of resources to fulfil the role. HHSs should refer to the current enterprise bargaining agreement for nurses and midwives. There are separate industrial arrangements for caseload midwifery. HHSs should refer to the current enterprise bargaining agreement for nurses and midwives.
- Costs associated with travel to the woman's home for 1-2 midwives travelling together or separately for:
  - an appointment during the antenatal period (attended by 1 or 2 midwives)
  - attendance for the birth (attended by 2 midwives)
  - attendance for postnatal care (attended by 1 midwife).
- Ongoing and refresher training for staff.
- Replacement of equipment (clinical, logistic and communications).
- Costs associated with documentation and IT connectivity.
- Evaluation and program review costs.

Specific equipment and technology

Health services may wish to consider purchasing or leasing:

- Laptops (with consideration given to security associated with remote access to the HHS network and electronic medical records).
- Mobile phones with top coverage (containing relevant numbers of senior clinicians for additional consultation and support).
- Vehicles for midwives attending homebirths.
- It is recommended that each midwife in an MGP carry his or her own homebirth kit in the event of planned and unplanned homebirth.
- HHSs should consider consulting with the Neonatal Retrieval Service and/or ANTS-NQ

Retrieval Service and refer to relevant HHS guidelines about the resuscitation equipment required to support women at home.

- In line with current recommendations from the Queensland Clinical Guidelines for Neonatal Resuscitation, HHSs should ensure that a self-inflating bag is included in the neonatal resuscitation kit at every homebirth, in the event of failure of the other resuscitation equipment.

Develop a communication and engagement strategy

Engaging with the community

HHSs will need to consider how and when they communicate with women and the community about their homebirth program. HHSs should ensure consistency in the information provided, in particular about the model of care, eligibility and the potential risks and benefits for women who may be eligible for a homebirth. A communication and engagement plan may assist HHSs to define key messages and to identify the style and timing of various communication strategies such as community forums, newsletters, social media, media releases or information sheets about the program. HHSs should consider the most appropriate methods of communication to women of culturally and linguistically diverse backgrounds.

Engaging with women

- Women who are eligible and choose to have a homebirth should receive clear verbal and written information about their care during their journey. Information should be based on the best available evidence and updated as new evidence emerges. HHSs may consider a range of media such as handouts or fact sheets for women, webpages or articles.
- Women should receive clear, high-quality information about:
  - Eligibility for a homebirth and how eligibility may change during pregnancy
  - The benefits and risks of giving birth at home
  - The situations that may require an emergency transfer to hospital and what happens in the event of a transfer
  - Screening tests and appointments
  - The Australian Charter of Healthcare Rights
  - HHS expectations of the woman
  - Other considerations

HHSs must ensure that their medication safety policies align with current legislation and consider whether it requires updating to reflect the specific policies and procedures that apply to the homebirth program and align with HiTH (Hospital in The Home) guidelines.

Further resources:
https://www.health.qld.gov.au/__data/assets/pdf_file/0011/140600/g-resus.pdf
https://www.health.qld.gov.au/__data/assets/pdf_file/0022/736213/maternity-decline-guide.pdf
https://www.aihw.gov.au/reports/mothers-babies/maternity-models-of-care/contents/data-quality-and-availability#about
https://qheps.health.qld.gov.au/caru/hith

4. Providing a homebirth program

This section covers the operational management of the homebirth program across the care periods of antenatal (care during pregnancy to the onset of labour), intrapartum (care during labour and birth) and postnatal (care immediately after the birth and extending to six weeks).

HHS guidelines

- Care provided as part of the homebirth program is consistent with the HHSs policies and procedures.
- Care is provided in the antenatal, intrapartum and postnatal periods according to documented care pathways.
- HHSs consider the cultural and linguistic needs of women in their community to ensure culturally competent services are available to women.
- The recording of accurate, complete and timely information about a woman and her baby allows information to be shared between health professionals and supports the provision of safe and appropriate care

Implementation guidance

Antenatal care

- Antenatal care of women in a homebirth program should be provided in accordance with the National Pregnancy Care Guidelines[18], and the HHSs existing antenatal care arrangements with the following recommended additional steps:
  - The home environment is assessed to ensure it is safe and suitable for a homebirth (as per Queensland Clinical Guidelines Publicly funded homebirth guideline).
  - Emergency resuscitation equipment (oxygen and suction equipment) is delivered to the woman's home prior to the commencement of labour.
  - HHSs consider the optimal number of antenatal visits required to establish a relationship with the primary midwife.
  - The support midwife meets the woman at least once with the primary midwife and provides antenatal care in the absence of the primary midwife.

Culturally appropriate care

To ensure equitable access to the homebirth program for all women, HHSs should consider cultural competence at the organisational, structural and clinical level. An example of each level is provided below:

- Organisational level: cultural competence is embedded within a HHSs quality improvement framework to build capacity at an organisational level.
- Structural level: women have access to readily obtainable, translated health information, including appropriate interpreting services (face-to-face or telephone) throughout the antenatal period.
- Clinical level: staff receive regular training and development to ensure they are culturally competent with knowledge of health issues impacting upon different population sub-groups, experience in comprehensive assessment and awareness of support services available for referral.

HHSs should maintain effective linkages with support services and community-based providers of care, such as the local Aboriginal and Torres Strait Islander Community Controlled Health Organisations and refugee health organisations, to ensure streamlined processes for referral and a seamless transition between services for women from culturally diverse backgrounds.

Documentation

HHSs should ensure there are policies and procedures in place to support midwives to maintain appropriate documentation. Every effort should be made to align documentation processes with existing hospital practices. This includes using the same hospital record as for the health service's other maternity services and providing patients with the Queensland Maternity Record (or equivalent) if used by the HHS.

The following is a guide to the types of information that should be recorded in the patient record in addition to the information collected on a woman who is being cared for by the HHSs maternity services:

- Discussions with the woman about giving birth at home.
- Discussions and details of counselling provided if a woman is to be transferred out of the homebirth program and into hospital-based care.
- Advice provided to the woman about the need to go to hospital should complications arise.
- Discussions around informed consent including a woman's specific wishes and decisions.
- Details of the home assessment and discussions during the home visit.
- Meetings with support people.
- Discussions with relevant health care professionals regarding care of the woman and her baby.
- Discussions with the woman about the risks and consequences of declining particular tests or treatments.
- Clinical observations, rationale and discussions when transfer to hospital-based care is clinically required or requested.

Intrapartum care

HHSs must ensure that women know who to contact when labour commences and are provided with up-to-date details for all relevant contacts. Information about what to do in the case of an emergency, or in the event that the primary midwife cannot be contacted should also be provided to women. HHSs are responsible for providing a safe and timely response to women in labour. This includes having 'back up' systems in place to manage midwife fatigue and availability.

The intrapartum care pathway commences when the midwife has assessed the woman to be in labour. When the midwife arrives at a woman's home and labour is established, the woman becomes an admitted patient via Hospital in The Home (HiTH). Women admitted to HiTH are under the care of the hospitals birth suite and attending midwives. A key role of the primary midwife is to keep the woman informed of her progress in a timely manner to enable informed decision-making. The primary midwife is responsible for completing all documentation.

Accepted practice in homebirth programs across Australia is that two midwives are required to provide safe care during the intrapartum period. The timing of when the second midwife is required to attend should be clearly defined in homebirth policies and procedures.

The presence of two midwives at the birth will:

- provide support and clinical assistance in emergency situations
- provide an environment for consultation if a second opinion is required
- enable safe working practices for midwives
- provide capacity for documentation during the birth.

A woman is discharged from HiTH at the time the primary midwife determines that discharge is clinically appropriate in the circumstances and/or the woman and/or infant is transported to the relevant health service for admission.

When a woman declines recommended care consistent with health service guidelines

A woman has the right to give and rescind consent at any time. HHSs must ensure women are informed of the requirements of the homebirth program and how a woman's decisions may influence her eligibility for the program. It is suggested that women are provided with information on the types of conditions or complications that may require recommendation to transfer to hospital-based care. Use of the Queensland Health Declining Recommended Maternity Care resources assists with open communication and provides a tool for clear documentation and decision support. Please utilise First Nations specific resources where appropriate.

HHSs should develop clear policies to support midwives in the appropriate management of situations that are inconsistent with professional advice or standard practice. Examples include (but are not limited to) situations where a woman declines care or declines the professional advice of the midwife. In some cases, declining care may result in a woman no longer being eligible for a homebirth, if it is a safety concern. It is the responsibility of HHSs to determine what circumstances may result in a woman no longer being eligible. The basis of a woman declining care should be discussed with the woman to ascertain her concerns and to enable clear communication with the multidisciplinary team of the woman's needs.

Transfer from home to hospital and escalation processes

For some women, transfer from home to hospital will be necessary. A transfer to hospital is not a 'failed' homebirth but an indication of a service working well.

Every publicly funded homebirth program must have clearly documented policies, procedures and processes to ensure the safe, timely and appropriate transfer of women if required from home to hospital at any stage in her maternity continuum of care (i.e. onset of labour, during labour, after birth). Specifically, the policies and procedures will:

- define what complications require recommendation to transfer
- address the communication process between the midwives providing homebirth and the hospital-based maternity service including escalation procedures
- ensure appropriate transfer arrangements are in place for all women, and relevant to the level of risk and urgency should the need for transfer arise
- devise the necessary clinical pathways and guidelines to support all types of transfer
- ensure women are informed about the indications and possible need for transfer, including what will happen should she and/or her baby require transfer to hospital
- ensure timely review and reporting of all transfers.

Health services will need to consider the level of care they provide and whether there may be emergency situations in labour and birth that would require a woman to be transferred to a HHS with a higher level of care. Where this is relevant, referring HHSs should consult with the receiving HHSs

during the planning stage to clearly document processes and referral pathways.

The Queensland Clinical Guideline Publicly funded homebirth guideline provides an example set of transfer protocols and procedures.

When a woman declines emergency transfer to hospital in active labour

Homebirth programs must have clear policies about staff actions where a woman declines to transfer in labour including when to call an ambulance, the escalation process within the HHS, care while awaiting transfer and documentation of events and discussions.

Postnatal care

The care of the mother and baby after the birth will be provided by the midwife in attendance at the homebirth. The postnatal care for women in homebirth is provided in line with the existing maternity service arrangements.

HHSs should maintain effective linkages with support services and community-based providers of care, such as General Practitioners and Community Maternal and Child Health services, to facilitate timely access to postnatal care and a seamless transition between services following discharge from the homebirth program. Where there is continuity of midwifery carer models offered the midwife usually continues care postnatally until the baby is 2-6 weeks old.

Further resources:

https://www.health.qld.gov.au/__data/assets/pdf_file/0023/143087/g-stillbirth.pdf

5. Data, reporting and monitoring a homebirth program

HHS guidelines

- An evaluation framework is established before a homebirth program commences.
- Mechanisms for collecting, monitoring and reporting data are in place from commencement of the homebirth program.

Data and reporting

The requirements for HHSs to report and monitor on relevant activity, quality and safety events for maternity services apply to those services delivered through a publicly funded homebirth program.

The requirements that have specific relevance to homebirth programs include sentinel events and occupational violence through Riskman.

The *Public Health Act 2005*. Chapter 6, 'Part 1 - Perinatal Statistics' includes a requirement that perinatal data be provided to the Chief Executive of the Department of Health for every baby born in Queensland. Birth data is reported to the Chief Executive via Statistical Services Branch Queensland Perinatal Data Collection.

In accordance with the Queensland Health admitted patient guidelines a homebirth is considered to be a planned, admitted maternity episode and therefore must be reported to the Queensland Hospital

Admitted Patient Data Collection (QHAPDC). The Queensland Perinatal Data Collection Form is Appendix 6.

Coding

Once assessed by the midwife to be in established labour, the woman will be admitted as per the Hospital in The Home (HITH) services admission guidelines described in Section 4.9 of the relevant Queensland Health Admitted Patient Data Collection manual.

The birth registration is to be completed in the Hospital Based Client Information System (HBCIS) as soon as possible after birth.

The Australian Institute of Health and Welfare (AIHW) developed the Maternity Care Classification System (MaCCS) data collection tool (DCT) to collect information on the models of care available at each maternity service and HHSs are requested to ensure this reflects local models of care provided. Please refer Sections 5.43 and 5.44 of the relevant Queensland Perinatal Data Collection manual for more information.

Program evaluation

HHSs should continually review and revise their service delivery models to ensure they are consumer-centred, evidence based and organised for safety. Clinical data collection and monitoring of performance and patient outcomes for homebirth should be embedded in the HHSs usual processes for maternity services, however the episodes that relate to homebirthing services should be considered specifically.

Initially it is recommended that monitoring and review of data – especially clinical outcomes, safety incidents and compliance with protocols – is formal, frequent and comprehensive, as this is a new service model. There should be a 'clear line of sight' to the health service executive on the program outcomes.

Periodic program evaluation is important for the department, agencies, clinicians and the community as it:

- demonstrates accountability
- ensures that there is transparency in assessing if a program is achieving its goal and objectives (and if not, why not?)
- determines whether programs are efficient and sustainable
- assists with future planning
- identifies opportunities for improvement.

Formal and informal approaches to evaluation of the program are recommended and HHSs may wish to develop audit tools specific to their service or use validated tools.

Table 2 identifies how health services may monitor, review and evaluate their homebirth program to allow continuous improvement of their model.

Table 2: Suggested frequency for monitoring, reviewing and evaluating a homebirth program

Process	Suggested frequency
Debrief meetings between multidisciplinary team	
Clinical audits	
Clinical outcome data (maternal and neonatal outcomes, including outcomes of all including transfers)	
Documentation audits and compliance to protocols and procedures	
Staff meetings	
Staff satisfaction surveys	
Women's experience surveys	
Complaints and compliments	
Riskman reports	
Maternity consumer group feedback	

As publicly funded homebirth is a new maternity service model for HHSs, it is recommended that a formal program evaluation or review be undertaken at 12 months and then annually after the program is established unless an earlier review is indicated by clinical outcomes or trends.

The proposed framework for evaluation should be developed before the service begins so the necessary data items are able to be captured and reported on.

Further resources:

health.qld.gov.au/__data/assets/pdf_file/0027/1260756/2324-qhapdc-manual-v1.0.pdf

https://www.legislation.qld.gov.au/view/html/inforce/current/act-2005-048#ch.

Aboriginal and Torres Strait Islander considerations

Queensland public hospital services and staff recognise and commit to the respect, understanding and application of Aboriginal and Torres Strait Islander cultural values, principles, differences and needs when caring for Aboriginal or Torres Strait Islander patients.

Every individual Hospital and Health Service is responsible for achieving successful provision of culturally appropriate services to and with Aboriginal and Torres Strait Islander individuals and their communities within their respective catchment.

Equally, the respect and acknowledgement extended to Aboriginal and Torres Strait Islander people will be extended to all participants, irrespective of ethnic background or membership of community groups.

Human rights

The guidance for health services outlined in this document is based on the Right to health services – Section 37 of the Human Rights Act 2019.

Approval and implementation

Policy Custodian	Policy Contact Details	Approval Date	Approver
Chief Midwife Officer	OCNMO_MidwiferyQLD@health.qld.gov.au	*15 February 2024*	*Deputy Director General, Clinical Excellence Queensland*

Version Control

Version	Date	Comments
V 1.0	*15 February 2024*	New guideline

References

1. Hilder L, Zhichao Z, Parker M, Jahan S, Chambers GM 14. Australia's mothers and babies 2012. Perinatal statistics series no. 30. Cat. no. PER 69. Canberra: AIHW.

2. Hutton, E.K., et al. (2014). Protocol: systematic review and meta-analyses of birth outcomes for women who intend at the onset of labour to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital. Systematic Reviews, 3, 55. https://doi.org/10.1186/2046-4053-3-55

3. Qld statistical services branch perinatal reports 2011-2020, https://www.health.qld.gov.au/hsu/peri

4. Reitsma et al. (2020). Maternal outcomes and birth interventions among women who begin labour intending to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: A systematic review and meta-analyses. EClinical Medicine, 21, 100319.

5. Hutton et al. (2019). Perinatal or neonatal mortality among women who intend at the onset of labour to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: A systematic review and meta-analyses. EClinical Medicine, 14, 59–70.

6. Scarf, V.L. et al. (2018). Maternal and perinatal outcomes by planned place of birth among women with low-risk pregnancies in high-income countries: A systematic review and meta-analysis. Midwifery, 62, 240-255.

7. Rossi, A. C. & Prefumo, F. (2018). Planned home versus planned hospital births in women at low-risk pregnancy: A systematic review with meta-analysis. European Journal of Obstetrics & Gynecology and Reproductive Biology, 222, 102-108.

8. Donate-Manzanares, M., Rodríguez-Cano, T., Rodríguez-Almagro, J., Hernández-Martínez, A., Santos-Hernández, G., & Beato-Fernández, L. (2021). Mixed-method study of women's assessment and experience of childbirth care. Journal of advanced nursing, 77(10), 4195–4210. https://doi.org/10.1111/jan.14984

9. Callander, E. J., Bull, C., McInnes, R., & Toohill, J. (2021). The opportunity costs of birth in Australia: Hospital resource savings for a post-COVID-19 era. Birth (Berkeley, Calif.), 48(2), 274–282.

10. Scarf, V. L., Yu, S., Viney, R., Cheah, S. L., Dahlen, H., Sibbritt, D., Thornton, C., Tracy, S., & Homer, C. (2021). Modelling the cost of place of birth:a pathway analysis. BMC health services research,21(1), 816. https://doi.org/10.1186/s12913-021-06810-9

11. Australian College of Midwives. (2019). Position Statement for Planned Birth at Home. Retrieved from: https://www.midwives.org.au/common/Uploaded%20files/_ADMIN-ACM/Planned-Birth-at-Home-Position-Statement--2019.pdf

12. Royal Australian and New Zealand College of Obstetricians and Gynaecologists. (2017). Home Birth. Retrieved from: https://ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/Home-Births-(C-Obs-2)-Review-July-17.pdf?ext=.pdf

13. Catling-Paull, C., Foureur, M. J., & Homer, C. S. E. (2012) Publicly-funded homebirth models in Australia. Women and Birth, 25(4), 152-158. https://doi.org/10.1016/j.wombi.2011.10.003

14. White, C., Tarrant, M., Hodges, R., Wallace, E. M., Kumar, A. (2020). A pathway to establish a publicly funded home birth program in Australia. Women and Birth, 33, e420-e428. https://dx.doi.org/10.1016/j.wombi.2019.09.007

15. AIHW (Australian Institute of Health and Welfare) 2023 Maternity Care Classification System, Cat. No. PER 118, Australian Government

16. McLachlan H, McKay H, Powell R, et al. Publicly-funded home birth in Victoria, Australia: Exploring the views and experiences of midwives and doctors. Midwifery 2016; 35: 24–30. [PubMed] [Google Scholar]

17. Yanan Hu, Jyai Allen, David Ellwood, Valerie Slavin, Jenny Gamble, Jocelyn Toohill, Emily Callander, The financial impact of offering publicly funded homebirths: A population-based microsimulation in Queensland, Australia, Women and Birth, 2023, ISSN 1871-5192

18. Department of Health (2020) Clinical Practice Guidelines: Pregnancy Care. Canberra: Australian Government Department of Health.

Appendix 1

Organisational readiness checklist

Key questions to consider in assessing organisational readiness for a home birth program	Self-assessment
Is the HHS Board and executive committed to a home birth program?	Yes ☐ No ☐ Unsure ☐
Are senior clinical staff committed to a home birth program?	Yes ☐ No ☐ Unsure ☐
Has the HHS considered the governance arrangements for the home birth program?	Yes ☐ No ☐ Unsure ☐
Are midwifery staff interested in being able to offer a publicly funded home birth program?	Yes ☐ No ☐ Unsure ☐
Have midwives expressed an interest in adding home birth to their practice context?	Yes ☐ No ☐ Unsure ☐
Are staff from different disciplines committed to working together in a multidisciplinary team?	Yes ☐ No ☐ Unsure ☐
Has the local community expressed an interest in a home birth program?	Yes ☐ No ☐ Unsure ☐
Has the HHS assessed the implications of offering a home birth program? How will any risks be addressed?	Yes ☐ No ☐ Unsure ☐
Have any issues with organisational readiness been identified? How will these be addressed?	Yes ☐ No ☐ Unsure ☐
Will a home birth program complement current care options? Will it be feasible?	Yes ☐ No ☐ Unsure ☐
Is the HHS prepared to work with other health services and partner groups to implement a home birth program?	Yes ☐ No ☐ Unsure ☐
Does the HHS have adequate financial and human resources to establish and operate a home birth program?	Yes ☐ No ☐ Unsure ☐
Will the health service support home birth midwives with the required education, time for training and normal processes such as peer review?	Yes ☐ No ☐ Unsure ☐
Will the HHS allow time for staff to implement the program?	Yes ☐ No ☐ Unsure ☐
Is a home birth program supported under current industrial arrangement	Yes ☐ No ☐ Unsure ☐