RESTACKING THE ODDS

INDICATOR GUIDE

Quality, quantity and participation indicators across early years services and why they're important

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Quality, quantity and participation indicators across early years services and why they're important.

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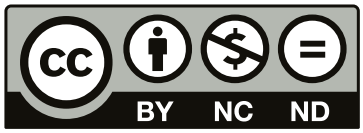

Restacking the Odds is a collaboration between the Centre for Community Child Health at the Murdoch Children's Research Institute, Bain & Company and Social Ventures Australia. RSTO acknowledges the support of project partners, the Paul Ramsey Foundation and Seer Data.

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The Centre for Community Child Health is a department of The Royal Children's Hospital and a research group of the Murdoch Children's Research Institute.

We acknowledge the Traditional Owners of the land on which we work and pay our respect to Elders past, present and emerging.

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RESTACKING THE ODDS

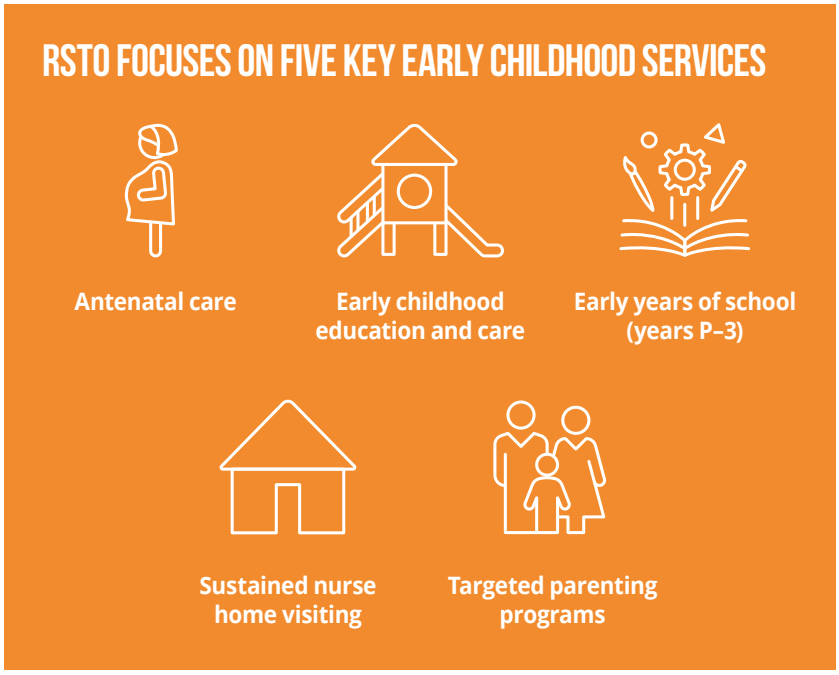
Restacking the Odds (RSTO) is a project that seeks to reduce inequity by ensuring that children and families can and do access a combination of high-quality, evidence-informed stacked services where and when they need them. By focusing on the early years and enabling services to better meet the needs of children and families, RSTO helps to create the conditions that enable all children to thrive.

BETTER EVIDENCE, STRONGER PRACTICE

RSTO's unique approach uses evidence to focus on HOW to work differently to improve outcomes for children, families and communities. It aims to develop the skills and knowledge of service providers and community-based early years initiatives for collecting, understanding and using evidence-based lead indicators to enable them to answer key questions including:

- **Quantity:** Are sufficient services available?
- **Quality:** Are we delivering high-quality services?
- **Participation:** Who is accessing our services?

Service providers, community initiatives and government policymakers can then use this information to identify approaches for addressing key service gaps for more effective and equitable service delivery.



There is no single solution to the complex challenges faced by many children, families and communities. Improving children's health, development and wellbeing requires combining or 'stacking' multiple effective evidence-based strategies across the early years (0-8 years) and implementing them concurrently and continuously.

RSTO focuses on participation in five services to boost children's health development and wellbeing: antenatal care, sustained nurse home visiting, early childhood education and care, targeted parenting programs and the early years of school. Together these five services:

- contribute to improved early childhood outcomes
- focus on children AND parents
- run throughout childhood
- are available in many Australian communities
- can be targeted to those with the greatest needs.

HOW TO USE THIS GUIDE

This guide provides evidence-based lead indicators for five key early childhood services: antenatal care, nurse home visiting, early childhood education and care, parenting programs and the early years of school (P-3). It is designed for use by:

- ☑ local community organisations
- ☑ government staff e.g. funders of services across the early years and policy advisors
- ☑ service providers
- ☑ measurement and evaluation specialists
- ☑ researchers.

The framework of lead indicators can be used to:

- better measure service performance and enable more effective and efficient services (and avoid wasting time, money and effort on approaches that fail to deliver results)
- better respond to the needs of children and families in their community, especially those experiencing vulnerability and disadvantage
- learn and share with others striving to improve children's outcomes
- capture evidence for insights, innovation and advocacy.

Priority groups

The term 'priority groups' is used throughout the guide to identify populations who may experience greater susceptibility to adverse health or learning outcomes as a result of structural inequities. Priority groups include: pregnant women under 18 years of age, refugees or asylum seeker populations, disability populations, Aboriginal and Torres Strait Islander populations, Health Care Card holders, children in out-of-home care, and culturally and linguistically diverse (CALD) populations.

Early childhood services and indicators

Lead indicators are provided for 5 services: antenatal care, sustained nurse home visiting, early childhood education and care, targeted parenting programs and the early years of school.

Indicators that measure quality, quantity and participation are provided for each service (with the exception of the early years of school as participation and quantity for this service are stipulated by legislation).

Indicator tables are colour coded to reflect different types of indicators.

Quality indicators are in orange tables.

Participation indicators are in blue tables.

Quantity indicators are in orange and white tables

A description is supplied for each indicator including why it is important and how it is calculated. A glossary is provided for each service area.

Benchmarks

Where an indicator has a national or state-based benchmark this is identified this using the following symbols:

- Indicator has a measure that enables national comparison
- Indicator has a measure that enables Victorian comparison
- Indicator has a measure that enables NSW comparison

Overtime we intend to collect and add in other state benchmarks.

Visit Restacking the Odds

For more information about Restacking the Odds visit: www.rch.org.au/ccch/Restacking_the_Odds

LEAD INDICATORS

WHAT IS A LEAD INDICATOR?

Lead indicators provide information essential to knowing whether you are on track to achieve your desired goals/outcomes. They allow service providers and other stakeholders to regularly assess performance and progress, and course correct when required. They reveal what families and children are experiencing, and allow service providers, government (local, state, federal) and communities to learn and adjust regularly, rather than waiting for years to see outcomes.

Outcome indicators provide information about whether you have achieved your expected goals.

Table 1 provides an example of a RSTO lead indicator in each of the 5 services, the potential action that could be taken to improve the performance of that indicator and the relevant outcome indicator.

Table 1: Examples of lead indicators

SERVICE	LEAD INDICATOR	POTENTIAL ACTION	OUTCOME INDICATOR
Antenatal care	% Of pregnant women who smoke who are referred to an evidence-based stop smoking service	✔ Implement a systematic process to ensure all pregnant women who smoke are referred to an evidence-based stop smoking service	% of pregnant women who smoke
Sustained nurse home visiting	% of antenatal and early post-partum visits where education /support on breastfeeding is offered	✔ Ensure program guidelines require nurses to provide early education and support, ideally before birth	% of women who breastfeed
Early childhood education and care	% of all children attending ECEC for 15 hours or more per week for the two years before starting formal school	✔ Overcome barriers to low participation rates e.g. reach out to CALD populations	Proportion of children at school entry who are developmentally on track in health, learning and psychosocial wellbeing
Parenting programs	Number of places available in supported parenting programs led by qualified facilitators, relative to the target population	✔ Provide adequate training to facilitators of parenting programs	% of children with behavioural issues
Early years of school	% of P-3 classroom teachers that provide parents with strategies to use when reading with children at home	✔ Ensure teachers are provided with appropriate reading and learning packs to use at home	% of children at expected level in reading (NAPLAN)

The RSTO indicators define how the service strategies should be delivered across three dimensions:

Quantity: this refers to the **physical access to local services in sufficient quantity**. Quantity indicators help to determine the amount of resource and infrastructure needed to deliver the service for a given population at the right quality and dose.

Quality: services or programs with 'quality' are those where **delivery aligns to the desired outcomes in the evidence-base**. High quality is needed to deliver benefits for children - especially for children from priority groups who are likely to benefit most. The way they are delivered, and by whom, are key determinants of quality.

Participation: refers to both **who uses the service** and **how much (dosage)**. Children and families need to attend at the right dosage levels for benefits to be realised. Research shows children and families experiencing disadvantage or adversity are more likely to miss out.

How were the indicators developed?

The indicators were developed based on a comprehensive review of best practice via systematic literature reviews and targeted literature scans for relevant strategies. These indicators were then assessed and refined in consultation with experts in each area. Indicators were subsequently tested in 7 communities to determine which were pragmatic to collect, resonated with communities, and provided robust measures to stimulate service provider, community and government action.

ANTENATAL CARE

Quality care during pregnancy monitors and supports the health and wellbeing of mothers and babies. This section includes a glossary of terms and:

- 21 universal quality indicators
- 3 hypertensive disorder quality indicators
- 2 mental health quality indicators
- 3 diabetes quality indicators
- 2 participation indicators
- 5 quantity indicators.

QUALITY INDICATORS | Universal

INDICATOR	WHY IT MATTERS	CALCULATION
QL 1 % of pregnant women with continuity of care from a named midwife	Women who experience continuity of care led by a midwife experience better outcomes.	**Numerator:** Pregnant women who attended 80% or more appointments with the same named midwife **Denominator:** All pregnant women who attended 5 or more appointments
QL 2 % of pregnant women who have a complete record of the minimum set of routine test results available	Screening and assessment for maternal health issues are important for mother and baby health.	**Numerator:** pregnant women who have all 'minimum set' routine test results available **Denominator:** Pregnant women who attended one or more antenatal appointments
QL 3 % of pregnant women who have their blood pressure recorded at all routine appointments	Measuring blood pressure is used to identify existing high blood pressure and hypertension. Hypertension can lead to poor infant outcomes (e.g. low birth weight, preterm birth).	**Numerator:** Pregnant women who have their blood pressure recorded at all routine appointments **Denominator:** Pregnant women who attended one or more antenatal appointments
QL 4 % of pregnant women whose BMI is calculated and recorded	A low BMI during pregnancy increases the risk of having a low birth weight baby and/or preterm birth. A high BMI during pregnancy increases the risk of baby being born preterm and/or low birth weight, gestational diabetes and hypertensive disorders, congenital anomalies and neural tube defects.	**Numerator:** Pregnant women with BMI calculated and recorded **Denominator:** Pregnant women who attended one or more antenatal appointments
QL 5 % of pregnant women whose smoking status is recorded	Smoking in pregnancy increases the risk of ectopic pregnancy, preterm birth, miscarriage, reduced birth weight, small-for-gestational-age baby, stillbirth, fetal and infant mortality and sudden infant death syndrome.	**Numerator:** Pregnant women asked about their tobacco use, with the answer documented **Denominator:** Pregnant women who attended one or more antenatal appointments

QUALITY INDICATORS | Universal

INDICATOR	WHY IT MATTERS	CALCULATION
QL 6 % of pregnant women whose alcohol use is recorded	Alcohol in pregnancy increases the risk of miscarriage, stillbirth, preterm birth and fetal alcohol spectrum disorder.	**Numerator:** Pregnant women asked about their alcohol use, with the answer documented **Denominator:** Pregnant women who attended one or more antenatal appointments
QL 7 ▲ % of pregnant women whose risk for family violence is recorded	Violence poses serious health risks to pregnant women and babies. Women exposed to violence during pregnancy are at risk of miscarriage, preterm birth, having a low birth weight baby, and are more likely to develop depression in the postnatal period.	**Numerator**: Pregnant women asked about family violence, with the answer documented **Denominator**: Pregnant women who attended one or more antenatal appointments
QL 8 % of pregnant women whose mental health history is recorded	Mental health conditions, particularly in their more severe form are often associated with impaired functioning e.g. a woman's ability to care for her infant and the formation of secure infant attachment, which may in turn be associated with poorer outcomes in the child.	**Numerator:** Pregnant women whose mental health history is recorded **Denominator:** Pregnant women who attended one or more antenatal appointments
QL 9 % of pregnant women with a mental health screen	Pregnant women are more vulnerable to depression and anxiety or worsening of symptoms. Unmanaged mental health issues can result in adverse outcomes such as miscarriage, preterm birth and small-for-gestational-age baby.	**Numerator:** Pregnant women with a complete mental health screen **Denominator:** Pregnant women who attended one or more antenatal appointments
QL 10 % of pregnant women who have their risk factor for pre-eclampsia recorded at their booking appointment	Pre-eclampsia can lead to fetal loss, preterm labour, low birth weight, perinatal death and gestational diabetes.	**A.** **Numerator:** Pregnant women who have their risk factor for pre-eclampsia recorded at their booking appointment **Denominator:** Pregnant women who attended one or more antenatal appointments **B.** **Numerator:** Pregnant women who information available that risk factor for pre-eclampsia can be calculated **Denominator:** Pregnant women who attended one or more antenatal appointments
QL 11 % of pregnant women who have a recorded measure of symphysis fundal height at all routine appointments after 24 weeks 0 days gestation	Allows detection of small-for-gestational age fetus monitor for slow or static growth.	**Numerator:** Pregnant women who have symphysis fundal height recorded at all routine appointments after 24 weeks 0 days gestation (inclusive) **Denominator:** Pregnant women who attended one or more antenatal care appointments after 24 weeks 0 days gestation

QUALITY INDICATORS | Universal

INDICATOR	WHY IT MATTERS	CALCULATION
QL 12 **%** of pregnant women who complete testing for gestational diabetes at 24 weeks 0 days to 28 weeks 6 days and have their test results available and acknowledged	Women with gestational diabetes have a higher risk of induced labour and are more likely to have a preterm birth, high birth weight, caesarean birth, hypertension and longer hospital stay than women without diabetes, and their babies are at risk of poorer outcomes.	**Numerator:** Pregnant women who complete testing between 24 weeks 0 days to 28 weeks 6 days with results available and acknowledged **Denominator:** Pregnant women who attended one or more antenatal appointments
QL 13 % of pregnant women who have a recorded fetal presentation at 30 weeks gestation	Fetal presentation after 30 weeks will influence birth plan, measuring pre-labour allows for interventions that promote vaginal birth.	**Numerator:** Pregnant women who have fetal presentation during 30 weeks gestation recorded at their appointment **Denominator:** Pregnant women who attended one or more antenatal care appointment after 30 weeks 0 days gestation
QL 14 % of pregnant women with a BMI 30 kg/m2 or > who are referred for personalised advice from a trained person on healthy eating and physical activity	Personalised advice on healthy eating and physical activity may be effective in improving women's eating behaviours and may prevent excessive weight gain. This may reduce risk of gestational diabetes, hypertensive disorders, and fetal growth.	**Numerator:** Pregnant women with a BMI 30 kg/m2 or > referred for personalised advice from a trained person on healthy eating and physical activity **Denominator:** pregnant women with a BMI 30 kg/m2 or > (incudes those whose BMI is not calculated – as per QI 5 but have height and weight available for calculation)
QL 15 % of pregnant women who smoke who are referred to an evidence-based stop smoking service	Smoking cessation interventions reduce smoking rates in pregnant women which in turn may reduce the incidences of low birth weight and preterm births.	**Numerator:** Pregnant women who smoke (>1, <1, or spontaneous) referred to an evidence-based stop smoking service **Denominator:** Pregnant women who have their smoking status recorded
QL 16 % of pregnant women who received genetic screenings before 13 weeks 6 days and have results available and acknowledged	Allows diagnosis of genetic/ chromosomal anomalies.	**Numerator:** Pregnant women who received genetic screenings before 13 weeks 6 days and have results available and acknowledged **Denominator:** Pregnant women who have their smoking status recorded
QL 17 % of pregnant women who complete an ultrasound between 18 weeks 0 days and 20 weeks 6 days and have their results available and acknowledged	Allows diagnosis of structural anomalies. Sensitivity in detecting structural anomalies increases after 18 weeks gestation. Detection of structural anomalies before 20 weeks gestation gives women the choice of terminating the pregnancy (where this is permitted under jurisdictional legislation).	**Numerator:** Pregnant women who complete an ultrasound between 18 weeks 0 days and 20 weeks 6 days, and have their results available and acknowledge **Denominator:** All pregnant women
QL 18 % of pregnant women with confirmed breech presentation after 37 weeks 0 days gestation who are offered and eligible for external cephalic version	Turning the baby (e.g. using external cephalic version [ECV]) reduces the number of babies who are breech at term, thereby improving the chance of a vaginal birth.	**Numerator:** Pregnant women with confirmed breech presentation after 37 weeks 0 days gestation (inclusive) who are offered and eligible for External Cephalic Version **Denominator:** All pregnant women diagnosed with breech presentation (diagnosis at or after 37 weeks 0 days)

QUALITY INDICATORS | Universal

INDICATOR	WHY IT MATTERS	CALCULATION
QL 19 % of pregnant women attending a 40 week appointment who are offered a vaginal examination for membrane sweeping	Membrane sweeping may be of benefit in preventing prolonged pregnancy, particularly in first pregnancies.	**Numerator:** Pregnant women who attended a 40 week appointment offered a vaginal examination for membrane sweeping **Denominator:** Pregnant women who attend a 40 week appointment
QL 20 % of pregnant women attending a 41 week appointment who are offered a vaginal examination for membrane sweeping	Membrane sweeping may be of benefit in preventing prolonged pregnancy, particularly in first pregnancies.	**Numerator:** Pregnant women who attended a 41 week appointment offered a vaginal examination for membrane sweeping **Denominator:** Pregnant women who attend a 41 week appointment
QL 21 % of pregnant women provided with verbal and written information regarding normal fetal movements during the antenatal period.	Decreased fetal movement indicates risk of adverse outcomes including: intrauterine growth restriction, fetal death or preterm birth. Antenatal education about fetal movement has been shown to reduce the time from maternal perception of decreased fetal movements to help-seeking behaviour.	**Numerator:** Pregnant women provided with verbal and written information regarding normal fetal movements **Denominator:** Pregnant women who attended one or more antenatal appointments

QUALITY INDICATORS | Hypertensive disorders

INDICATOR	WHY IT MATTERS	CALCULATION
HT 1 % of pregnant women identified at risk of pre-eclampsia who are advised to take low-dose aspirin daily	Aspirin consumption reduces risk of pre-eclampsia in at-risk women and is likely to reduce intrauterine growth restriction by about 10%.	**Numerator:** Pregnant women with increased risk of pre-eclampsia, advised to take low-dose aspirin daily **Denominator:** All pregnant women with increased risk of pre-eclampsia
HT 2 % of pregnant women with diagnosed hypertension who receive escalation of care	Women with chronic hypertension are at greater risk of pregnancy complications such as: placental abruption, super imposed pre-eclampsia, fetal loss, preterm labour, low birth weight, perinatal death, or gestational diabetes.	**Numerator:** Pregnant women with diagnosed hypertension who receive escalation of care (any of: treatment [medication], admission, increased frequency of: BP monitoring, proteinuria monitoring) **Denominator:** Pregnant women diagnosed with hypertension
HT 3 % of pregnant women diagnosed with pre-eclampsia have attended obstetrician appointment/s	Obstetricians have specialised training in antenatal care, labour care and postnatal care. They are trained in high-risk pregnancy and birthing and can perform caesarean sections. They can prescribe and monitor medication interventions.	**Numerator:** Pregnant women diagnosed with pre-eclampsia have attended obstetrician appointment/s **Denominator:** Pregnant women diagnosed with pre-eclampsia

QUALITY INDICATORS | Mental health

INDICATOR	WHY IT MATTERS	CALCULATION
MH 1 % of pregnant women identified at risk of mental health issues who have a documented mental health plan	Pregnant women are more vulnerable to depression and anxiety or worsening of symptoms. Unmanaged mental health issues can result in adverse outcomes such as miscarriage, preterm birth and small-for-gestational-age baby.	**Numerator:** Pregnant women identified at risk of mental health issues with a documented mental health plan **Denominator:** Pregnant women identified at risk of mental health
MH 2 % of pregnant women referred to a mental health professional who are followed up by an ANC provider	PW are more likely to engage in mental health services if they are supported through the process through follow up by an antenatal care provider e.g. gentle reminder, encouragement, reassurance.	**Numerator:** Pregnant women referred to a mental health professional who are followed up by an antenatal care provider **Denominator:** Pregnant women referred to a mental health professional

QUALITY INDICATOR | Diabetes

INDICATOR	WHY IT MATTERS	CALCULATION
DM 1 % of pregnant women identified at risk of gestational diabetes at the booking appointment who receive testing for gestational diabetes and have their test results available and acknowledged	Women with gestational diabetes have a higher risk of induced labour, preterm birth, high birth weight, caesarean birth, hypertension and longer hospital stay than women without diabetes. Their babies are more likely to require special care nursery/neonatal intensive care admission.	**Numerator:** Pregnant women identified at risk of gestational diabetes, at the booking appointment who receive testing for gestational diabetes, and have their test results available and acknowledged **Denominator:** All pregnant women identified at risk of gestational diabetes
DM 2 % of pregnant women with pre-existing diabetes who are seen by members of the diabetes team within 1 week of their triage	Women with pre-existing diabetes are more likely to have preterm birth, induced labour, caesarean birth, hypertension and longer hospital stay than women without pre-existing diabetes. Their babies have higher rates of stillbirth, high birth weight, low Apgar score and admission to special care nursery/ neonatal intensive care unit.	**Numerator:** Pregnant women who are seen by members of the diabetes team within 1 week of triage **Denominator:** Pregnant women who are seen by members of the diabetes team
DM 3 % of pregnant women with pre-existing diabetes who have their HbA1c results available and acknowledged	Early treatment of women with abnormal HbA1c is associated with a reduced risk of pre-eclampsia.	**Numerator:** Pregnant women with pre-existing diabetes who have their HbA1c results available and acknowledged **Denominator:** Pregnant women with pre-existing diabetes

PARTICIPATION INDICATORS

INDICATOR	WHY IT MATTERS	CALCULATION
P1a ● % of pregnant women who attend a booking appointment within the first trimester	Women attending antenatal care in the first trimester of pregnancy have lower maternal and perinatal mortality than women who attend late or not at all.	**Numerator:** Pregnant women who attend their booking appointment within 12 weeks 0 days gestation **Denominator:** All pregnant women
P1b % of pregnant women recognised in a priority group who attend a booking appointment within the first trimester	Pregnant women recognised in a priority group are at risk of poor maternal and perinatal outcomes. They are also more likely to have complex health needs and face multiple barriers accessing pregnancy care and navigating the healthcare system.	**Numerator:** Pregnant women recognised in a priority group who attend their booking appointment within 12 weeks 0 days gestation **Denominator:** Pregnant women experiencing vulnerability
P2a ● % of pregnant women who attend at least the recommended number of antenatal care appointments – 10 for 1st pregnancy, 7 for subsequent pregnancies	Pregnant women experiencing their first pregnancy may require additional education and support e.g. what to expect at each stage of pregnancy.	**Numerator:** Pregnant women who attend at least the minimum number of recommended appointments **Denominator:** Pregnant women recognised in priority group
P2b % of pregnant women recognised in a priority group who attend at least the recommended number of antenatal care appointments – 10 for 1st pregnancy, 7 for subsequent pregnancies	There is some evidence that perinatal mortality may be increased with reduced visits in some vulnerable pregnant women. Pregnant women experiencing their first pregnancy may require additional education and support e.g. what to expect at each stage of pregnancy.	**Numerator:** Pregnant women recognised in a priority group who attend at least the minimum number of recommended appointments **Denominator:** Pregnant women recognised in priority group

QUANTITY INDICATORS

INDICATOR	WHY IT MATTERS	CALCULATION
QN 1 Number of antenatal care facilities per 10,000 women of child-bearing age	To ensure adequate health infrastructure to cater for all pregnant women in a community.	**Numerator:** Number of child-bearing women (18-49 years) in the community **Denominator:** Number of antenatal care facilities in the community
QN 2 ● Number of maternity beds per 1000 pregnant women	To ensure an adequate number of maternity beds to cater for all pregnant women in a community.	**Numerator:** Number of maternity beds in the community **Denominator:** Number of 1,000 pregnant women
QN 3 ● Number of practicing general practitioners per 10,000 women of child-bearing age	To ensure an adequate number of general practitioners to cater for all pregnant women in a community.	**Numerator:** Number of full time GPs actively registered and employed in the community **Denominator:** Number of child-bearing women (18-49) in the community

QUANTITY INDICATORS

INDICATOR	WHY IT MATTERS	CALCULATION
QN 4  Number of registered midwives working in the antenatal care facilities per 10,000 women of child-bearing potential	To ensure an adequate number of general practitioners to cater for all pregnant women in a community.	**Numerator:** Number of full time Midwives actively registered and employed in the community **Denominator:** Number of child-bearing women (18-49) in the community
QN 5 Number of OB/GYNs working in the antenatal care facility per 10,000 women of child-bearing potential	To ensure an adequate number of obstetricians/gynaecologists to cater for all pregnant women in a community.	**Numerator:** Number of full time OB/GYNs actively registered and employed in the community **Denominator:** Number of full time OB/GYNs actively registered and employed in the community

ANTENATAL CARE | GLOSSARY OF TERMS

Maternal health screening and assessment

Blood group and rhesus D status	Identifies women who are Rhesus-incompatible or ABO-incompatible and who require Anti-D to avoid anaemia or severe jaundice in the fetus.
Haemoglobin	Undertaken at booking appointment and 28 weeks. Identifies iron-deficient women. Early supplementation avoids adverse outcomes such as preterm birth.
Haemoglobinopathies screen	Undertaken at booking appointment. Identifies the presence of sickle cell disease, beta thalassaemia, anaemia, microcytosis, abnormalities in the pre symptomatic phase. Presence of which influences treatments, procedures and fetus health.
Hepatitis B virus screen	Undertaken at booking appointment. Identifies women with the virus so that they can be given antiviral medication to minimise the risk of transmission to the fetus and vaccination of the baby after birth.
Hepatitis C virus screen	Undertaken at booking appointment. Identifies women with the hepatitis C virus who have an increased risk of preterm birth. Second, pregnancy treatment and interventions that increase mother-to-fetus transmission can be avoided.
HIV test	Undertaken at booking appointment. Identifies women with the virus so that they can be given antiviral medication to minimise the risk of transmission to the fetus.
Midstream specimens of urine for asymptomatic bacteriuria	Undertaken at booking appointment. Identifies women who have a urine infection - if present and untreated during pregnancy it can progress to kidney infection.
Red-cell alloantibodies	Undertaken at booking appointment and 28 weeks. Screens for antibodies in the mother's blood that might cross the placenta and attack the fetus' red blood cells, this causes hemolytic disease of the newborn. Early detection allows treatment and prevention of adverse outcomes.

Rubella susceptibility screen	Undertaken at booking appointment. Maternal rubella infection can result in spontaneous miscarriage, fetal infection (causing eye, hearing or hear problems), stillbirth, or fetal growth restriction. There is no treatment to prevent or reduce mother-to-child transmission of rubella once infection has been detected in pregnancy. Rubella vaccination is contraindicated in pregnancy, however if the mother is non-immune then vaccination can be delivered post birth to reduce risk in future pregnancies.
Syphilis screen	Undertaken at booking appointment. Identifies infected women so that they can be treated and so that transmission to babies can be prevented. In pregnancy, syphilis can result in spontaneous miscarriage or stillbirth or cause congenital syphilis infection.
Urine test for proteinuria	Undertaken at booking appointment. Proteinuria in the first trimester (0-12 weeks) may suggest kidney disease or urinary tract infection. After 20 weeks pregnancy, proteinuria is associated with pre-eclampsia.
At risk of gestational diabetes	Women with any 1 of these risk factors should be offered testing for gestational diabetes. body mass index above 30 kg/m2 previous macrosomic baby weighing 4.5 kg or above previous gestational diabetes family history of diabetes (first-degree relative with diabetes) minority ethnic family origin with a high prevalence of diabetes.
Body mass index	Calculated as: weight (kg)/height (m2).
CALD	Culturally and linguistically diverse. CALD communities are those with diverse languages, nationalities and ethnic backgrounds.
Confirmed breech presentation	Recorded that the women is a breech presentation in the medical chart.
Continuity of care from a named midwife	This is when a named registered midwife is responsible for providing all or most (≥80%) of a woman's antenatal and postnatal care and coordinating their care should they not be available.
Documented mental health plan	Documented indicates the plan was recorded in chart that appropriate referrals were made.
Family violence	Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members. This includes psychological, physical, sexual, financial and emotional abuse.
Provided with verbal and written information regarding normal foetal movements during the antenatal period.	Requires documentation of verbal correspondence accompanied by written information (e.g. brochure). This information should include a description of the changing patterns of movement as the fetus develops, normal wake/sleep cycles and factors that may modify the mother's perception of fetal movements.
"...recorded fetal presentation."	This means that fetal presentation (which specifies which anatomical part of the fetus is leading, that is, is closest to the pelvic inlet of the birth canal (cephalic, breech, or shoulder presentation)) should be documented in the medical chart.
Referred to a mental health professional who are followed up by ANC provider	In cases where it was recorded in the medical chart that the woman was referred to a mental health professional, the researcher checked whether there was follow-up by an antenatal care provider. This is some form of documentation by the antenatal care provider where they stated that they followed up with the patient to confirm that they received an appointment and/or went to the appointment with the mental health professional.

"...referred for personalised advice from an evidence-based stop smoking service"	This means that there is a referral letter for smoking cessation included in the medical chart, or there is some documentation in the medical chart to say, "referred to smoking cessation".
Risk factors for pre-eclampsia	Women are at an increased risk of pre-eclampsia if they have one high risk factor or more than one moderate risk factor for pre-eclampsia. High risk factors include hypertensive disease in a previous pregnancy, chronic kidney disease, autoimmune disease, type 1 or type 2 diabetes, chronic hypertension. Moderate risk factors include first pregnancy, age 40 years or older, pregnancy interval of more than 10 years, body mass index (BMI) of 35 kg/m2 or more at first visit, family history of pre-eclampsia, or multiple pregnancy.
Testing for gestational diabetes	Use the 2-hour 75 g oral glucose tolerance test (OGTT) to test for gestational diabetes. Oral glucose tolerance test (OGTT) results must be available and acknowledged.* (*refer to definition of "available and acknowledged" above")
"...test results available and acknowledged...."	This means that: a) The test results were included in the patient file b) If the results were not written/typed into medical records, but the result slip (e.g. for pathology/genetic screen/ultrasound) was inserted into records – the pathology slip must have been signed off by the practitioner i.e. it was acknowledged.
Triage	To triage is to decide the order of treatment.
Priority groups	Some populations may experience greater susceptibility to adverse health or learning outcomes as a result of structural inequities. Priority groups include: pregnant women experiencing vulnerability, refugees or asylum seeker populations, disability populations, Aboriginal and Torres Strait Islander populations, Health Care Card holders, children in out-of-home Care, and culturally and linguistically diverse (CALD) populations.

SUSTAINED NURSE HOME VISITING

Quality sustained nurse home visiting programs help parents to care for their children in supportive home learning environments. They generally target risk and protective factors related to prenatal health, sensitive and competent care-giving, and early parental lifecourse outcomes.

Based on the strength of evidence there were seven programs that were ranked as being 'supported by evidence', in that there was consistent evidence of benefit that was generalisable and applicable to the Australian context. These supported programs include: Nurse Family Partnership, Family Nurse Partnership, Maternal Early Childhood Sustained Home Visiting, Minding the Baby, Pro Kind, right@home and VoorZorg.

This section includes a glossary of terms and:

- 7 content quality indicators
- 15 process quality indicators
- 11 provider quality indicators
- 14 participation indicators
- 6 quantity indicators.

QUALITY INDICATORS

INDICATOR	WHY IT MATTERS	CALCULATION
QL The provision of one of 7 sustained nurse home visiting (SNHV) that reaches the high-quality threshold for each of the three quality domains of content, process, and nurse-provider.	Sustained nurse home-visiting programs improve child and parent outcomes.	Is a quality sustained nurse home visiting program provided?

QUALITY INDICATORS | Content

INDICATOR	WHY IT MATTERS	CALCULATION
QL 1 % of visits addressing home learning (e.g. talking, reading)	A stimulating home and family environment contributes to improving the long-term wellbeing and academic achievement of children.	**Numerator:** Number of visits addressing home-learning environment **Denominator:** Number of total visits
QL 2 % of visits addressing parenting skills (e.g. sensitive and responsive parenting, behaviour and discipline)	Sustained nurse home-visiting programs that address parenting issues have been shown to have benefits for child cognitive outcomes, parent behaviours and skills, and maternal outcomes.	**Numerator:** Number of visits addressing parenting skills **Denominator:** Number of total visits
QL 3 % of visits in which problem-solving skills are taught	Equip parents with skills that enable them to independently problem-solve.	**Numerator:** Number of visits in which problem-solving skills are taught **Denominator:** Number of total visits

QUALITY INDICATORS | Content

INDICATOR	WHY IT MATTERS	CALCULATION
QL 4 % of antenatal & early post-partum visits where education/support on breastfeeding is offered	Offering breastfeeding support has benefits for breastfeeding intention, initiation and duration.	**Numerator:** Number of antenatal visits and early post-partum visits less than or equal to 6 weeks after birth where breastfeeding support is offered **Denominator:** Number of antenatal visits and early post-partum visits less than or equal to 6 weeks after birth
QL 5 % of visits that address the parent's documented goals and aspirations	Patient focused support can benefit families by fostering long-term planning specific to their individual needs and concerns.	**Numerator:** Number of visits focused on at least one of the goals or aspirations identified at the beginning of the service **Denominator:** Number of total visits
QL 6 % of parents referred from a sustained nurse home visiting (SNHV) program who are offered program specific support from evidence-based programs (e.g. Triple P; Crib to Cradle; Promoting First Relationship; Smalltalk; Learning to Communicate)	Programs that target specific issues important to families and are supported by the evidence help improve outcomes.	**Numerator:** Number of parents referred to evidence-based programs **Denominator:** Number of parents referred from SNHV program
QL 7 % of parents provided information about local and free or low-cost community engagement opportunities (e.g. play groups; toy libraries; pram walking sessions; library rhyme or story time)	Community engagement is beneficial for establishing supportive relationships which in turn has benefits for maternal and child outcomes.	**Numerator:** Number of parents provided information about local and low-cost community engagement opportunities **Denominator:** Number of parents in the program

QUALITY INDICATORS | Process

INDICATOR	WHY IT MATTERS	CALCULATION
QL 8 % of parents who have their aspirations and goals documented	Documenting target issues allows the health care provider to understand the family's needs and monitor their progress.	**Numerator:** Number of parents with their aspirations and goals documented **Denominator:** Number of parents in the program
QL 9 % of parents with continuity of care	Continuity of care is beneficial for parent and child outcomes.	**Numerator:** Number of parents with same nurse for 85%+ of visits **Denominator:** Number of parents in the program with 1+ nurse visit
QL 10 % of parents with progress against aspirations and goals documented	This is important to monitor a family's progress and their response to intervention.	**Numerator:** Number of parents with progress against aspirations or goals documented **Denominator:** Number of parents in the program

QUALITY INDICATORS | Process

INDICATOR	WHY IT MATTERS	CALCULATION
QL 11 % of culturally and linguistically diverse (CALD) parents receiving a translated version of the program/ service and/or support from an interpreter	Providing a translator or translated material increases program comprehension and inclusivity for families from non-English speaking backgrounds.	**Numerator:** Number of CALD parents receiving translated program or having an interpreter present **Denominator:** Number CALD parents in program
QL 12 % of new nurse home-visitors observed implementing the program and assessed for quality	Nurse home-visitors should undergo quality assurance audits to ensure program delivery is optimal.	**Numerator:** Number of new nurse home-visitors observed implementing program and assessed for quality **Denominator:** Number of new nurse home-visitors
QL 13 % of parents whose smoking status is recorded in the first visit	Smoking is associated with poor outcomes for mother and child. Smoking should be recorded so it can be addressed as part of the intervention.	**Numerator:** Number of parents whose smoking status is recorded in the first visit **Denominator:** Number of parents in the program
QL 14 % of parents whose mental health status is recorded in the first visit	Mental health problems can affect a woman's ability to care for her infant. Women's mental health status should be recorded so it can be addressed as part of the intervention.	**Numerator:** Number of parents whose mental health status is recorded in the first visit **Denominator:** Number parents in the program
QL 15 % of parents whose family violence status is recorded in the first visit	Family violence is associated with poor outcomes for mother and child. This risk should be recorded so that it can be addressed as part of the intervention.	**Numerator:** Number of parents whose family violence risk is recorded between the 2nd-5th visit **Denominator:** Number of parents in the program
QL 16 % of parents whose alcohol and substance use status is recorded in the first visit	Alcohol and substance misuse can affect a woman's ability to care for her infant. This behaviour should be recorded so it can be addressed as part of the intervention.	**Numerator:** Number of parents whose alcohol and substance use is recorded in the first visit **Denominator:** Number parents in the program
QL 17 % of parents with a mental health concerns who are referred for psychological intervention	Mental health problems can affect a woman's ability to care for her infant. A specialised referral should be offered to identified women.	**Numerator:** Number of parents with a mental health concerns referred to psychological intervention **Denominator:** Number of parents with a mental health problem in the program
QL 18 % of parents experiencing domestic violence who are referred to an evidence-based support service	Family violence is associated with poor outcomes for mother and child. A specialised referral should be offered to identified women.	**Numerator:** Number of parents experiencing family violence referred to an evidence-based support service **Denominator:** Number of parents who experience family violence
QL 19 % of parents with drug or alcohol problems referred to an evidence-based support service	Alcohol and substance misuse can affect a woman's ability to care for her infant. A specialised referral should be offered to identified women.	**Numerator:** Number of parents with alcohol/substance misuse referred to evidence support service **Denominator:** Number of parents with alcohol/substance misuse problems

QUALITY INDICATORS | Process

INDICATOR	WHY IT MATTERS	CALCULATION
QL 20 % of parents experiencing financial difficulty provided information about avenues for assistance	Financial difficulty can affect the mother's ability to care for her infant. Women experiencing financial difficulty should be provided with information about avenues for assistance.	**Numerator:** Number of parents with financial difficulties provided info on assistance avenues **Denominator:** Number of parents with financial difficulty
QL 21 % of parents given opportunity to provide nurse feedback during program/ service implementation	Feedback and communication enable individualised program content, strengthening women's self-efficacy and self-advocacy and increasing program flexibility and service implementation development.	**Numerator:** Number of parents with opportunity to provide nurse feedback during program **Denominator:** Number of parents in the program
QL 22 % of parents given opportunity to provide confidential program feedback	Provision of confidential program feedback is important to ensure program fidelity (i.e. the degree to which an intervention or program is delivered as intended.)	**Numerator:** Number of parents with the opportunity to provide confidential program feedback **Denominator:** Number of parents in the program

QUALITY INDICATORS | Provider

INDICATOR	WHY IT MATTERS	CALCULATION
QL 23 % of parents who rate the program and nurse-family relationship highly (average score >80% on satisfaction measures) on exit survey (administered regardless of completion)	This is important to ensure program fidelity (i.e. the degree to which an intervention or program is delivered as intended) and to monitor the nurse-family relationship which is important for successful program delivery.	**Numerator:** Number of parents rating program and nurse-family relationship highly (avg score >80%) **Denominator:** Number of parents taking exit survey
QL 24 % of nurse home-visitors with specialised child & family training and at least 2 years nursing experience	An experienced nursing staff has the skill base for successful program delivery.	**Numerator:** Number of nurse home-visitors with specialised child & family training **Denominator:** Number of nurse home-visitors
QL 25 % of nurse home-visitors with program/service specific training	Specialised training provides staff with an opportunity to update their skills in accordance with the most up to date evidence.	**Numerator:** Number of nurse home-visitors with program/service specific training **Denominator:** Number of nurse home-visitors
QL 26 % of nurse home-visitors provided training which included role playing exercises	Role-play enables parents to rehearse techniques and strategies whilst receiving real-time feedback, improving parent outcomes.	**Numerator:** Number of nurse home-visitors provided training including role-play exercises **Denominator:** Number of nurse home-visitors

QUALITY INDICATORS | Provider

INDICATOR	WHY IT MATTERS	CALCULATION
QL 27 % of nurse home-visitors receiving monthly supervision including reflection (on experiences, thoughts, and feelings about visit) and not merely administration or case-management	Monthly reflective supervision is demonstrated to have positive effects on several parent outcomes by affording the staff the ability to be more effective in supporting family needs.	**Numerator:** Number of nurse home-visitors receiving monthly supervision including reflection **Denominator:** Number of nurse home-visitors
QL 28 % of nurse home-visitors who have received Family Partnership Training or an equivalent working in partnership with families program	Training in Family Partnerships is demonstrated to have a positive effect on parent-child interaction, the child's developmental progress and psychological functioning, resulting in better life outcomes.	**Numerator:** Number of nurse home-visitors who received Family Partnerships Training (or equivalent) **Denominator:** Number of nurse home-visitors
QL 29 % of nurse home-visitors who have undertaken professional development relevant to their current work in the past 12 months	Engaging in professional development is important for skill maintenance and ensuring that staff are up to date with the most recent research.	**Numerator:** Number of nurse home-visitors who have undertaken relevant PD in the past 12 months **Denominator:** Number of nurse home-visitors
QL 30 % of supervisors provided supervision-specific training	Supervision of program providers with a reflective component is a key element to effective program implementation and fidelity.	**Numerator:** Number of supervisors provided supervisor-specific training **Denominator:** Number of supervisors
QL 31 % of nurse home-visitors with caseloads as defined by the program/service	Caseloads vary among programs. Adherence to a benchmark set around 20-30 cases per nurse are demonstrated to have the largest positive effect on a range of child/parent outcomes.	**Numerator:** Number of nurse home-visitors with caseloads as defined by the program/service **Denominator:** Number of nurse home-visitors
QL 32 Nurse home visitors have access to multi-disciplinary support	Access to multi-disciplinary support, particularly from social care practitioners, increases the effectiveness of SNHV programs.	**Numerator:** Nurse home visitors have access to multi-disciplinary support (practitioners of other professions available for advice and home visiting, within the team)
QL 33 % of nurse home-visitors provided training in cultural competence	Staff cultural competency has been demonstrated to result in higher levels of engagement including reaching some high-risk pregnant women.	**Numerator:** Number of nurse home-visitors provided training in cultural competence **Denominator:** Number of nurse home-visitors

PARTICIPATION INDICATORS

INDICATOR	WHY IT MATTERS	CALCULATION
P % of parents from priority groups who attend a high quality SNHV program	NHV programs that reach and retain mothers in priority groups are shown to improve mother and infant health outcomes and well-being.	**Numerator:** Number of parents from priority groups who attend a high quality SNHV program at the right dose (25+ visits by child age 2 years) **Denominator:** Number of parents from priority groups in the community
P1 % of parents receiving at least 25 home visits by child age 2 years	Advantages to increased intensity of SNHV programs during optimal time-period includes extended opportunities for rapport building, and individualising services for family's specific needs.	**Numerator:** Number of parents receiving 25+ visits by child age 2 years **Denominator:** Number of parents in program
P2 % of parents retained in program until child age 2 years	Participant retention indicates program effectiveness, and has potential to support the consensus that programs should start early (antenatal) and be available to families until child age 2 years.	**Numerator:** Number of parents retained in program until child age 2 years **Denominator:** Number of parents in the program
P3 % of parents receiving at least 15 home visits by child age 1 year	Advantages of high intensity home visits during fist year include assisting with adjustments to parenting roles and the intensive demands of early infant care.	**Numerator:** Number of parents receiving 15+ visits by child age 1 year **Denominator:** Number of parents in the program
P4 % of parents receiving fewer visits in the 2nd year than in the 1st year of being in the program	Understanding the impacts of SNHV program intensity in the first year is crucial to determining optimal dose requirements.	**Numerator:** Number of parents receiving fewer visits in the 2nd year than in the 1st year of being in the program **Denominator:** Number of parents in the program
P5 % of funded hours delivered	Funding levels are seen to impact on program participation, including increasing or inhibiting access to programs.	**Numerator:** Number of service hours delivered **Denominator:** Number of service hours funded
P6 % of parents from priority groups	Understanding demographics allows for tailoring of services to reach priority populations and increase program effectiveness.	**Numerator:** Number of parents from priority groups in program **Denominator:** Number of parents in program
P7 % of referred Aboriginal and Torres Strait Islander parents accepting a place	Identifying program uptake of key populations provides evaluation of program effectiveness and promotes strategies to increase participation in programs that will benefit intended community.	**Numerator:** Number of Aboriginal and Torres Strait Islander parents accepting a place **Denominator:** Number of Aboriginal and Torres Strait Islander parents referred
P8 % of referred CALD parents accepting a place	Identifying program uptake of key populations provides evaluation of program effectiveness and promotes strategies to increase participation in programs that will benefit intended community	**Numerator:** Number of CALD parents accepting a place **Denominator:** Number of CALD parents referred

PARTICIPATION INDICATORS

INDICATOR	WHY IT MATTERS	CALCULATION
P9 % of parents who are visited at home at least twice in the third trimester.	Higher frequency of home visits in the third trimester are associated with positive improvements in maternal behaviour and health outcomes for the mother and child.	**Numerator:** Number parents with 2+ visits in the 3rd trimester **Denominator:** Number of parents referred antenatally
P10 % of parents visited at least weekly in the first month following birth.	Intensive weekly home visiting in the first month following birth are associated with positive improvements in maternal behaviour and health outcomes for the mother and child.	**Numerator:** Number of parents with at least 4 visits in the first month after birth **Denominator:** Number parents referred before child age 1 month
P11 % of parents visited at least fortnightly to child age 3 months**.**	Continued early home-based intervention - delivered fortnightly for the child aged 1-3 months - are more successful in developing parent's self-efficacy and improving long term child health outcomes.	**Numerator:** Number of parents with at least 8 visits in the first 3 months after birth **Denominator:** Number of parents referred before child age 3 months
P12 % of parents from priority groups who are visited at home at least twice in the third trimester.	High frequency home-based intervention increases accessibly and likelihood of program participation for women from priority groups and is associated with positive improvements in maternal behaviour and health outcomes for the mother and child.	**Numerator:** Number of parents from priority groups with 2+ visits in third trimester **Denominator:** Number of parents from priority groups referred antenatally
P13 % of parents from priority groups who are seen at least weekly in the first month following birth.	Women from priority groups benefit from weekly home visiting in the first month following birth, with increased intensity being associated with positive improvements in maternal behaviour and health outcomes for the mother and child.	**Numerator:** Number parents from priority groups with weekly visits until child age 1 month **Denominator:** Number parents from priority groups referred by age 1 month

QUANTITY INDICATORS

INDICATOR	WHY IT MATTERS	CALCULATION
QN The number of places offered in a local community, in high quality SNHV programs.	To ensure adequate health infrastructure and workforce capacity for delivery of a nurse home-visiting program.	**Numerator:** Number of funded SNHV program places **Denominator:** Number of births in the community/1000
QN 1 MCH Facility Density: Number of Maternal and Child Health (MCH) centres in community per 1000 births	To ensure adequate health infrastructure and workforce capacity for delivery of a nurse home-visiting program.	**Numerator:** Number of MCH facilities in community **Denominator:** Number of births in the community/1000
QN 2 Funded SNHV program hours: Number per 1000 births	To ensure that health infrastructure and workforce capacity for delivery of a nurse home-visiting program.	**Numerator:** Funded SNHV program hours **Denominator:** Number of births in the community/1000
QN 3 Maternal and Child Health Nurse Density: Number per 1000 births	To ensure that adequate and appropriate workforce capacity for delivery of a nurse home-visiting program.	**Numerator:** Number SNHV nurses **Denominator:** Number of births in the community/1000
QN 4 Social Care Practitioner Density: Number in SNHV team per 1000 births	To ensure adequate and appropriate workforce capacity for delivery of a nurse home-visiting program.	**Numerator:** Number of Social Care Practitioners in SNHV team **Denominator:** Number of births in the community/1000
QN 5 Community Health Worker Density: Number in SNHV team per 1000 births	To ensure that adequate and appropriate workforce capacity for delivery of a nurse home-visiting program.	**Numerator:** Number of community health workers in SNHV team **Denominator:** Number of births in the community/1000

SUSTAINED NURSE HOME VISITING | GLOSSARY OF TERMS

Avenues for assistance for financial difficulty	Referrals to government programs made to parents experiencing financial difficulty.
Community engagement opportunities	Opportunities for social interactions with the community.
Cultural competence	Cultural competence is the ability to understand, communicate with and effectively interact with people across cultures. Cultural competence encompasses: being aware of one's own world view, developing positive attitudes towards cultural differences, and gaining knowledge of different cultural practices and world views.
Education/support on breastfeeding	Recorded in notes that there was a discussion about breastfeeding or breastfeeding education provided or resources provided (e.g. a pamphlet) about breastfeeding given.
Evidence based programs	Evidence- based programs are programs that have a sufficient evidence base and have undergone rigorous evaluation, demonstrating effectiveness in a specific population group.
Evidence-based support service for domestic violence	Evidence-based support for an intervention/program means that a research trial has been conducted to show that the intervention/program is effective. Some interventions/programs with evidence-based support for reducing domestic violence involve either (1) sessions of professional counselling or (2) contact with an intimate partner violence advocate. Sessions typically occur during and after pregnancy.
Evidence-based support for drug or alcohol problems	Evidence-based support for an intervention/program means that a research trial has been conducted to show that the intervention/program is effective. One example of a program with evidence-based support for reducing drug and alcohol misuse is the Durham Connects nurse home visiting program.
Family and domestic violence	'Family and domestic violence' covers a wide range of abusive behaviours committed in the context of intimate relationships such as those involving family members, children, partners, ex-partners, or caregivers. Family and domestic violence can include many types of behaviour or threats, including: physical violence, sexual abuse, emotional abuse, verbal abuse and intimidation, economic and social deprivation, damage of personal property and abuse of power. Types of relationships also vary.
Family Partnership Training	The Family Partnership Model is an innovative approach based upon an explicit model of the 'helping' process that demonstrates how specific 'helper' qualities and skills, when used in partnership, can enable parents and families to overcome their difficulties, build strengths and resilience, and fulfil their goals more effectively.
High-quality sustained nurse home visiting program	A high-quality sustained nurse home visiting program (SNHV) program is one of the seven sustained, supported programs – Nurse Family Partnership, Family Nurse Partnership, Maternal Early Childhood Sustained Home Visiting (MECSH), Minding the Baby, Pro Kind, right@home or VoorZorg –or a NHV program that reaches the high-quality threshold for each of the three quality domains of content, process, and nurse-provider.
Home learning	Home learning is an activity that a child is asked to complete outside of the school day, either on their own or with an adult.
Living with adversity	For the purposes of these indicators, we identify priority groups who may experience greater susceptibility to adverse health outcomes as a result of structural inequities. Priority groups include: pregnant women experiencing vulnerability, refugees or asylum seeker populations, disability populations, Aboriginal and Torres Strait Islander populations, Health Care Card holders, children in out-of-home care, and culturally and linguistically diverse (CALD) populations.

Multidisciplinary support	Multidisciplinary support is when professionals from a range of disciplines work together to deliver comprehensive care that addresses as many of the patient's needs as possible.
SNHV with continuity of care	Continuity of care means that the family has had the same nurse for ≥85% visits.
Parent	For the purpose of this report a parent is defined as a person performing the role of a primary caregiver to a child. This person may be different from the person who is the child's biological parent, for example it could include grandparents, stepparents, foster parents, or other carers
Priority groups	Priority groups are those populations who may experience greater susceptibility to adverse health outcomes as a result of structural inequities. Priority groups include: pregnant women experiencing vulnerability, refugees or asylum seeker populations, disability populations, Aboriginal and Torres Strait Islander populations, Health Care Card holders, children in out-of-home care, and culturally and linguistically diverse (CALD) populations.
Rate the program and nurse-family relationship highly	Average score >80% on satisfaction measures.
Referred for psychological intervention	This means that there is a referral letter for psychological intervention included in the medical chart, or there is some documentation in the medical chart to say referred to psychological intervention.
Right dose of SNHV	Completed a sufficient number of hours or sessions of the SNHV program.
Role playing exercise	A role-play exercise is an assessment activity in which candidates act out an imaginary scenario that closely mirrors a situation that could occur in the job they have applied for.

EARLY CHILDHOOD EDUCATION AND CARE

Quality early childhood education and care (ECEC) provides valuable play-based opportunities for learning, developmental and social engagement for children before they begin school. This section includes a glossary and:

- 1 quality indicator
- 2 participation indicators
- 1 quantity indicator.

QUALITY INDICATOR

INDICATOR	WHY IT MATTERS	CALCULATION
QL 1  The proportion of early childhood education and care (ECEC) services rated 'exceeding' the standard in quality areas 1, 4 and 5 and at least 'meeting' the standard in all other quality areas according to the ACECQA assessment	ECEC services are associated with improved child outcomes (cognitive/ academic and social-emotional).	**Numerator:** Number of 'ECEC services rated 'exceeding' the standard in quality areas 1, 4 and 5 and at least 'meeting' the standard in all other quality areas according to the ACECQA assessment **Denominator:** Number of ECEC services

PARTICIPATION INDICATORS

INDICATOR	WHY IT MATTERS	CALCULATION
P1 | universal  Proportion of all children attending ECEC for 15 hours or more per week for the two years before starting formal school	ECEC starting age, program duration and program intensity are associated with children's cognitive, academic, language and socio-emotional outcomes.	**Numerator:** Number of children who receive 15+ hours of ECEC two years before commencing formal schooling **Denominator:** Community population of children aged 3-5 years
P2 | targeted Proportion of children from priority groups who attend ECEC at least three years before starting formal school for 15 hours or more per week	Optimal levels of ECEC starting age, program duration and program intensity, associated with children's cognitive, academic, language and socio-emotional outcomes vary for children from priority groups.	**Numerator:** Number of children from priority groups who attend 15+ hours ECEC per week at least three years before starting formal school **Denominator:** Community population of children in priority groups that attend at least three years before school

QUANTITY INDICATOR

INDICATOR	WHY IT MATTERS	CALCULATION
QN 1  Number of ECEC places per target population (2-5 years) per 15 hours per week	To ensure adequate ECEC places for the population (2-5 years).	**Numerator:** ECEC approved places meeting 15h+ per week X proportion of places that are for 2-5 year olds **Denominator:** Number of theoretical places required to supply target population (2-5 years) with 15h+

EARLY CHILDHOOD EDUCATION AND CARE | GLOSSARY OF TERMS

ACECQA assessment	The Australian Children's Education and Care Quality Authority's quality rating system for early childhood education and care.
Quality areas 1,4 and 5 of ACECQA assessment	QA1: Educational program and practice QA4: Staffing arrangements QA5: Relationships with children
Children from priority groups (P2)	There is no common definition for children experiencing disadvantage however, some populations may experience greater susceptibility to adverse health outcomes as a result of structural inequities. RSTO identifies these are priority groups. Priority groups include: pregnant women experiencing vulnerability, refugees or asylum seeker populations, disability populations, Aboriginal and Torres Strait Islander populations, Health Care Card holders, children in out-of-home care, and culturally and linguistically diverse (CALD) populations.
Core population count	Core population (denominator) counts all 3-4 year olds and 30% of 5 year olds assuming 30% haven't started school yet (source Census data).

PARENTING PROGRAMS

Quality parenting programs can enhance parents' confidence and competence in providing the environments and experiences that help children to thrive.

Parenting programs, in this context, include interventions delivered to the parent with the aim to prevent, improve or optimise child behaviours or emotional outcomes.

Nine parenting programs met the criteria for 'supported', showing clear and consistent evidence of benefit. These include: Family Check-Up; Incredible Years; Parent-Child Interaction Therapy; Parent Management Training-Oregon Model; Triple P; Tuning into Kids; Child-Parent Psychotherapy; Common Sense Parenting; and Community Parent Education Program (COPE).

This section contains

- 1 quality indicator
- 1 participation indicator
- 1 quantity indicator.

QUALITY INDICATOR

INDICATOR	WHY IT MATTERS	CALCULATION
QL 1 The parenting program is one of the nine supported programs and is implemented according to the best practice parameters associated with that program.	Parenting programs rated as supported and administered according to program parameters are strongly linked with the ability to prevent, improve, or optimise child behavioural or emotional outcomes.	**Numerator:** The number of supported parenting programs offered and implemented according to best practice parameters **Denominator:** Total number of parenting program interventions that deliver a set curriculum to the parent with the aim to prevent, improve, or optimise child behavioural or emotional outcomes

PARTICIPATION INDICATOR

INDICATOR	WHY IT MATTERS	CALCULATION
P1 The proportion of targeted families (i.e. those with 2-8 year olds experiencing behaviour problems) enrolled in a supported parenting program who attend at least 85% of the program's sessions.	Higher levels of enrolment and retainment in supported programs are proven to benefit at-risk families. Identifying program uptake of key populations provides understanding of program effectiveness and promotes strategies to increase participation.	**Numerator:** The proportion of families enrolled in a supported parenting program who attend at least 85% of the programs' sessions **Denominator:** Estimated number of children aged 2–8 years in that local community at risk of, or with behavioural problems (~15% of the population)

QUANTITY INDICATOR

INDICATOR	WHY IT MATTERS	CALCULATION
QN 1 The number of places available in supported parenting programs led by qualified facilitators, relative to the target population.	To ensure adequate supported parenting program places - administered according to program parameters - are available for targeted families**.**	**Numerator:** The number of supported parenting programs places offered in a local community and led by qualified facilitators **Denominator:** Estimated number of children aged 2-8 years in that local community at risk of, or with, behavioural problems* (~15% of the target population)

*Estimates are based on Australian Bureau of Statistics 2016; and Longitudinal Study of Australian Children (LSAC)

PARENTING PROGRAMS | GLOSSARY OF TERMS

Supported parenting programs	One of the nine parenting programs demonstrating clear and consistent evidence of benefit for children and parents.
Targeted families	Parents whose children have behavioural issues (higher prevalence in families experiencing disadvantage).

EARLY YEARS OF SCHOOL

The early years of school provide foundational skills for lifelong learning. This section includes a glossary and:

- 6 content knowledge quality indicators
- 7 differentiated teaching quality indicators
- 3 social emotional support quality indicators
- 5 staff development and leadership quality indicators
- 2 peer teaching quality indicators
- 2 physical activity quality indicators
- 1 class size quality indicator
- 7 partnerships with families quality indicators.

Participation and quantity indicators are not included as they are stipulated by legislation.

QUALITY INDICATOR | Content knowledge

INDICATOR	WHY IT MATTERS	CALCULATION
QL1 % of P-3 classroom teachers who utilise the school curriculum to plan pedagogical content delivery	Pedagogical content knowledge is associated with student academic performance and a school curriculum can assist teachers to identify and consistently implement effective teaching strategies.	**Numerator:** Number of P-3 classroom teachers who use the school curriculum to plan pedagogical content delivery **Denominator:** Total number of P-3 classrooms teachers
QL2 % of P-3 classrooms that balance the amount of time spent in reading and writing activities	Literacy interventions that balance reading and writing instruction time have positive effects on both reading and writing outcomes.	**Numerator:** Number of P-3 classrooms that balance the amount of time spent in ready and writing activities **Denominator:** Total number of P-3 classrooms
QL3 % of P-3 classrooms implementing daily literacy instruction that explicitly builds skills in phonics, phonemic awareness, spelling, morphology, reading fluency and comprehension strategies, and handwriting	For each of the skills listed, explicit instruction has demonstrated positive effects on the respective child literacy outcomes. Additionally, explicit instruction in some skills leads to improved performance on other literacy skills/measures.	**Numerator:** Number of P-3 classrooms implementing daily literacy instruction that explicitly builds skills in phonemic, phonemic awareness, spelling, morphology, reading fluency and comprehension strategies and handwriting **Denominator:** Total number of P-3 classrooms
QL4 % of P-3 classrooms that incorporate regular use of manipulatives in numeracy instruction	Manipulative-based mathematics instruction has positive effects on a range of mathematical skills including understanding place value, arithmetic, fractions, geometry and algebra.	**Numerator:** Number of P-3 classrooms that incorporate regular use of manipulatives in numeracy instruction **Denominator:** Total number of P-3 classrooms teachers
QL5 % of P-3 classroom teachers who have formal training in evidence-based teaching methods	Subject-specific professional development has demonstrated positive effects on child academic achievement.	**Numerator:** Number of P-3 classroom teachers who have formal training in evidence-based teaching methods **Denominator:** Total number of P-3 classrooms teachers

QUALITY INDICATOR | Content knowledge

INDICATOR	WHY IT MATTERS	CALCULATION
QL6 % of P-3 classroom teachers who have formal training in evidence-based teaching methods who regularly coach other staff delivering P-3 literacy and numeracy	Compared with usual practice, teacher coaching has demonstrated positive effects on both teacher instruction and student achievement.	**Numerator:** Number of P-3 classroom teachers who have formal training in evidence-based teaching methods who regularly coach other staff delivering P-3 literacy and numeracy **Denominator:** Total number of P-3 classrooms

QUALITY INDICATOR | Differentiated teaching

INDICATOR	WHY IT MATTERS	CALCULATION
QL7 % of P-3 students whose academic development in literacy and numeracy is systematically assessed and documented	Systematic assessment and documentation of student academic development is critical for identifying student strengths and weaknesses and subsequently using this information to appropriately tailor instruction for students.	**Numerator:** Number of P-3 students whose academic development in literacy and numeracy is systematically assessed and documented **Denominator:** Total number of P-3 students
QL8 % of P-3 students whose literacy and numeracy instruction is tailored according to the results of systematic assessment of their academic development	Tailoring instruction to student needs leads to stronger academic development and more equitable instruction.	**Numerator:** Number of P-3 students whose literacy and numeracy instruction is tailored according to systematic assessment of academic development **Denominator:** Total number of P-3 students
QL9 % of P-3 students who regularly receive instruction in small groups	Small group instruction has demonstrated larger effects than whole-class instruction on early literacy skills such as letter name and letter sound knowledge.	**Numerator:** Number of P-3 students who regularly receive instruction in small groups **Denominator:** Total number of P-3 students
QL10 % of P-3 students for whom assessment data indicates the need for individualised instruction in literacy or numeracy who receive an evidence-based Tier 3 intervention	For a relatively small proportion of students, intensive individualised instruction is necessary for students who would otherwise struggle to meet minimum standards in literacy and numeracy development.	**Numerator:** Number of P-3 students who require individualised instruction according to assessment data who receive an evidence-based Tier 3 intervention **Denominator:** Total number of P-3 students for whom assessment data indicates the need for individualised instruction
QL11 % of P-3 classroom teachers with formal training in evidence-based differentiated teaching strategies	Differentiated teaching strategies (e.g. small group instruction, computerised differentiation, and individualised feedback) demonstrate positive effects on reading outcomes for P-3 children.	**Numerator:** Number of P-3 classroom teachers with formal training in evidence-based differentiated teaching strategies **Denominator:** Total number of P-3 classrooms teachers
QL12 % of staff with formal training or tertiary qualifications in special education for P-3 students needing additional support	A significant proportion of P-3 students struggle to respond adequately to whole-of-class instruction and will require specialised instruction to meet minimum standard benchmarks.	**Numerator:** Number of staff with formal training or tertiary qualifications in special education for P-3 students needing additional support **Denominator:** Total number of staff

QUALITY INDICATOR | Differentiated teaching

INDICATOR	WHY IT MATTERS	CALCULATION
QL13 % of staff delivering additional support to P-3 students who have formal training in the provision of evidence-based Tier 2 and Tier 3 learning interventions	A significant proportion of P-3 students struggle to meet minimum standard benchmarks in literacy and/or numeracy without the provision of Tier 2 and/or Tier 3 learning interventions.	**Numerator:** Number of staff delivering additional support to P-3 students who have formal training in the provision of evidence-based Tier 2 and Tier 3 learning interventions **Denominator:** Number of staff who are delivering additional support to P-3 students
QL14 % of P-3 lessons utilising digital technology for instruction in interactive rather than static conditions	Use of digital technology in classrooms has demonstrated positive effects on student academic achievement when the technology utilised requires student interaction rather than passive reception of information.	**Numerator:** Number of P-3 lessons using digital technology in interactive conditions **Denominator:** Number of P-3 lessons using digital technology
QL15 % of P-3 classrooms utilising interactive digital technology platforms to supplement literacy and numeracy instruction	Supplementing traditional classroom instruction with interactive digital technology platforms has been shown to improve student academic achievement across a range of subjects. There is strong evidence for the effectiveness of several technology-based literacy and numeracy interventions.	**Numerator:** Number of P-3 classrooms that use interactive digital technology platforms to supplement literacy and numeracy instruction **Denominator:** Total number of P-3 classrooms
QL16 % of P-3 classroom teachers who have received formal training in the use of interactive digital instruction materials and incorporate these in their classes	A plethora of interactive digital instruction materials are readily available, with many commercially produced, and mass marketed. Teachers should have formal training to build competence in selection and implementation of materials characterised by features with a strong evidence base.	**Numerator:** Number of P-3 classroom teachers who have received formal training in the use of interactive digital instruction materials and incorporate these in their classes **Denominator:** Total number of P-3 classrooms teachers
QL17 An evidence-based social-emotional development program is implemented across the school and activities to maintain the skills developed in the program are delivered on a regular basis (i.e. every term)	There is good evidence that universal and whole-of-school social-emotional development programs have positive effects on child psycho-social and academic development.	Is an evidence-based program being implemented and activities regularly undertaken?

QUALITY INDICATOR | Social emotional support

INDICATOR	WHY IT MATTERS	CALCULATION
QL18 % of families (with a child in grade P-3) indicating that their child feels safe at school on annual parent surveys	School climate is associated with child psycho-social wellbeing and academic development. There is a tendency for children who experience bullying, harassment, or exclusion at school to experience greater psychological distress and poorer academic achievement.	**Numerator:** Number of families (with a child in grade P-3) indicating that their child feels safe at school on annual parent surveys **Denominator:** Total number of families with a child in grade P-3

QUALITY INDICATOR | Social emotional support

INDICATOR	WHY IT MATTERS	CALCULATION
QL19 % of families (with a child in grade P-3) who agree on parent opinion surveys that teachers at the school treat students fairly and/or student behaviour is well managed	Parent perceptions of teacher competence in managing student behaviour provide an important measure of the school learning environment.	**Numerator:** Number of families (with a child in grade P-3) who agree on parent opinion surveys that teachers at the school treat students fairly **Denominator:** Total number of families with a child in grade P-3
QL20 % of P-3 classroom teachers who have completed formal training in evidence-based social-emotional development programs (such as teaching mindfulness strategies)	Implementation of school-based mindfulness strategies have demonstrated positive effects on measures of child mental health and well-being, cognition, and behaviour. Teachers are well-positioned to deliver mindfulness strategy instruction and promote regular and timely practice of such strategies.	**Numerator:** P-3 classroom teachers who have completed formal training in evidence-based social-emotional development programs **Denominator:** Total number of P-3 classroom teachers

QUALITY INDICATOR | Staff development and leadership

INDICATOR	WHY IT MATTERS	CALCULATION
QL21 % of staff professional development (PD) opportunities approved by the school principal that are characterised by both (a) active teacher learning experiences and (b) use of modelling/simulations	Professional development opportunities characterised by active teacher learning and use of modelling/simulations are associated with positive effects on teacher instruction and student academic achievement	**Numerator:** Number of approved PD opportunities that are characterised by both (a) active teacher learning experiences and (b) use of modelling/simulations **Denominator:** Total number of approved PD opportunities
QL22 % of approved PD opportunities that are informed by student needs (I.e. based on data)	PD opportunities specifically targeting areas of greatest student need should lead to substantive improvements in those areas.	**Numerator:** Number of PD opportunities informed by student needs **Denominator:** Total number of approved PD opportunities
QL23 % of P-3 classroom teachers with formal training in an evidence-based classroom management strategy	Implementation of evidence-based classroom management strategies can have a positive impact on student academic, behavioural and social-emotional development	**Numerator:** Number of P-3 classroom teachers with formal training in an evidence-based classroom management strategy **Denominator:** Total number of P-3 classroom teachers
QL24 % of professional learning courses undertaken by teachers that are evidence-based	Professional learning courses can be costly and are expected to translate to measurable improvements in student development. Utilising courses that are evidence-based should increase the likelihood that participation in PD leads to improved student outcomes	**Numerator:** Number of professional learning courses undertaken by teachers that are evidence-based **Denominator:** Total number of professional learning courses undertaken by teachers
QL25 % of teachers that currently receive in-service teacher coaching that is considered best practice	Positive effects on student achievement and teacher instruction have been observed in studies where best practice teacher coaching is a core component of professional development.	**Numerator:** Number of teachers that currently receive best practice in-service teacher coaching **Denominator:** Total number of P-3 classrooms teachers

QUALITY INDICATOR | Peer teaching

INDICATOR	WHY IT MATTERS	CALCULATION
QL26 % of P-3 classrooms that implement evidence-based peer tutoring activities in the weekly literacy/numeracy blocks	Peer tutoring has demonstrated positive effects across a range of subject areas and across a range of student abilities.	**Numerator:** % of P-3 classrooms implementing weekly evidence-based peer tutoring **Denominator:** Total number of P-3 classrooms
QL27 % of P-3 classroom teachers with formal training in evidence-based peer teaching methods	Peer tutoring effects are moderated by a range of factors. Formal training should prepare teachers with the tools to use the most effective peer teaching strategies	**Numerator:** Number of P-3 classroom teachers who have formal training in evidence-based peer teaching methods **Denominator:** Total number of P-3 classrooms teachers

QUALITY INDICATOR | Physical activity

INDICATOR	WHY IT MATTERS	CALCULATION
QL28 % of P-3 classrooms where physical activity is incorporated in academic instruction on a daily basis (whether by in class activity breaks, exercise prior to lessons, or use of movement to facilitate instruction)	Strategies to increase student physical activity during the school day generally demonstrate positive effects on school engagement, student learning and health outcomes.	**Numerator:** Number of classrooms where physical activity is incorporated in academic instruction on a daily basis **Denominator:** Total number of P-3 classroom
QL29 % of P-3 classroom teachers who have received at least some informal training in strategies to incorporate movement in academic instruction	Increasing the amount of time students spend in formal Physical Education classes may not be a viable strategy in the context of multiple and sometimes competing curricular demands. However, classroom teachers are well-positioned to incorporate movement with academic instruction and/or implement physical activity breaks during class.	**Numerator:** Number P-3 classrooms teachers who have received at least some informal training in strategies to incorporate movement in academic instruction **Denominator:** Total number of P-3 classroom teachers

QUALITY INDICATOR | Class size

INDICATOR	WHY IT MATTERS	CALCULATION
QL30 % Of P-3 classes that comprise 22 students or less	Student performance on standardised measures of reading, mathematics, and social science indicate that student academic achievement benefits more in classes comprised of 22 students or fewer, than larger classes.	**Numerator:** Number of classes with 22 students or less **Denominator:** Total number of P-3 classes

QUALITY INDICATOR | Partnerships with families

INDICATOR	WHY IT MATTERS	CALCULATION
QL31 % of P-3 teachers who are aware of the school's family partnership policy and implement it into their usual practice with families	Parent involvement with child learning both at home and at school is positively associated with child academic achievement. Family partnership policies provide some guidance for teachers to encourage parent/family involvement.	**Numerator:** Number of P-3 classroom teachers who are aware of the school's family partnership policy and implement it into their usual practice with families **Denominator:** Total number of P-3 classroom teachers
QL32 % of families (with a child in grades P-3) indicating that the school actively encourages and emphasises the importance of regular parent-child reading at home	Strategies to encourage parent-child reading at home generally have a positive effect on measures of child literacy development.	**Numerator:** Number of families (with a child in grades P-3) indicating that the school actively encourages the importance of regular parent-child reading at home **Denominator:** Number of families with a child in grades P-3
QL33 % of families (with a child in grades P-3) indicating that the school has provided information about specific strategies for parents to use when reading with their children	Most parents and caregivers are not trained literacy instructors or experts. Enjoyment and effectiveness of home-reading practice may benefit when parents or caregivers receive information about specific reading strategies to try.	**Numerator:** Number of families (with a child in grades P-3) indicating that the school has provided information about specific strategies to use when reading with their children **Denominator:** Number of families with a child in grades P-3
QL34 % of P-3 classroom teachers indicating that they have provided parents with strategies to use when reading with children at home	Parent and teacher perceptions of whether information about reading strategies has been communicated may differ. A divergence in family and teacher responses may indicate a need to improve communication strategies	**Numerator:** Number of P-3 teachers who indicate they provide parents with strategies to use when reading with children at home **Denominator:** Total number of P-3 classroom teachers
QL35 % of P-3 classroom teachers indicating that they monitor parent home reading on a regular basis (i.e. weekly)	A monitoring system may be useful for teachers to identify and respond to households requiring greater support with home reading practice	**Numerator:** Number of P-3 classroom teachers indicating that they monitor parent home reading on a regular basis **Denominator:** Total number of P-3 classroom teachers
QL36 % of P-3 classroom teachers who provide additional support to parents who have indicated difficulties with home reading practice	Families experiencing difficulties with home reading practice are less likely to persist when barriers are not adequately identified and addressed	**Numerator:** Number of P-3 classroom teachers who provide additional support to parents who have indicated difficulties with home reading practice **Denominator:** Total number of P-3 classroom teachers
QL37 % of P-3 classroom teachers who provide parents evidence-based materials to encourage and support reading at home	Evidence-based home reading strategies should translate to more successful and sustained practice	**Numerator:** Number of P-3 classroom teachers who provide parents evidence-based material to encourage and support reading at home **Denominator:** Total number of P-3 classroom teachers

Balanced reading and writing	Literacy instruction whereby no more than 60% of time is allocated to either reading or writing.
Best practice teacher coaching	To be considered best practice, coaching should be characterised by at least four of the six following criteria: individualised (1:1 feedback), intensive (conducted at least fortnightly), sustained (provided over a substantive period of time), context-specific (tailored to the teacher's' class), focussed (provides specific tasks for teachers to practice), and combined with curriculum-specific materials/resources.
Classroom management strategies	The strategies teachers use in the classroom to create an environment that supports and facilitates student learning. Examples of evidence-based classroom management strategies include PATHS, the Good Behaviour Game, the Incredible Years Teacher Classroom Management Program, and Proactive Classroom Management Program.
Classroom teachers	Teaching staff who regularly supervise the main literacy and numeracy instructional blocks (i.e. not casual relief teachers or specialist subject teachers such as those delivering instruction in Art, Science, Technology, Physical Education, or Languages Other Than English for example).
Differentiated teaching	Modifications to instructional delivery that enable teachers to tailor instruction to the needs of students across a range of abilities and learning needs.
Evidence-based interventions	Strategies that have demonstrated positive and statistically significant effects of at least moderate magnitude (i.e. standardised mean differences of 0.3 or more) or practical importance in at least two randomised controlled trials, on relevant outcomes (i.e. student academic performance or psychosocial development).
Formal training	Participation in external professional development opportunities (such as workshops run by independent organisations).
Informal professional development	Training or skill development opportunities that are developed and implemented internally by schools (e.g. coaching from more senior teachers in same school) or between school clusters (e.g. communities of professional development meetings involving teachers from multiple schools sharing knowledge or experience or 'practice wisdom').
P-3	The first year of school to grade 3 (children are approximately 5 to 8 years of age*).
Materials to support reading at home	Examples include materials that describe dialogic reading practices, interactive listening to child read, and tutoring specific skills such as alphabet knowledge or word reading strategies.
NAPLAN	The National Assessment Program – Literacy and Numeracy (NAPLAN) is a series of tests for Australian students in years 3, 5, 7 and 9 that provide information on progress in literacy and numeracy.
Peer tutoring	Structured activities in which same-age, cross-ability, student pairs receive explicit instruction and guidance in tutoring one another.
Tier 2 intervention	Additional small-group instruction for students who do not make adequate progress with classroom instruction or who fail to meet benchmarks on screening measures (intensity of intervention is varied according to group size, frequency and duration of intervention, and level of provider training).
Tier 3 intervention	Intensive one-to-one supports specifically targeting skills deficits that are provided when students do not adequately respond to Tier 1 or Tier 2 instruction.
Safety at school	Is defined in terms of response to school survey item "I feel safe at school"†, or items assessing whether students have experienced bullying or physical or verbal maltreatment (e.g. "I have been bullied at my school this term", "I have often been teased in an unpleasant way or called names at my school" ‡).

School encouragement of parent-child reading	Is defined in terms of response to school survey item, “This school works with me to support my child's learning"†, or other similar items available through state school surveys (e.g. “This school works with me to support my child's learning”, "Staff at this school are responsive to my enquiries” ◊).
Small group	Groups comprising no more than six students.

* As the term ‘kinder’ has often been used to refer to the first year of formal schooling (both in the international literature and some Australian states) we use the terms P-3 to refer to the early years of school.

‡ Survey item examples from the Framework for Improving Student Outcomes, Student Attitudes Survey

† An agreed student item in the Australian Curriculum and Assessment Reporting Authority (ACARA) School Survey

◊ Survey item examples from Queensland School Opinion Survey, Parent Items.

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