HEALTH RESPONSE TO FAMILY VIOLENCE:

2015 VIOLENCE INTERVENTION PROGRAMME EVALUATION

CENTRE FOR INTERDISCIPLINARY TRAUMA RESEARCH
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VIP
violence intervention programme

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HEALTH RESPONSE TO FAMILY VIOLENCE: 2015 VIOLENCE INTERVENTION PROGRAMME EVALUATION

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For more information visit www.aut.ac.nz/vipevaluation.

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Contents

EXECUTIVE SUMMARY iii

INTRODUCTION 1

METHODS 3

SYSTEM INFRASTRUCTURE (DELPHI AUDIT) 4

PROGRAMME INFORMATION 5

SNAPSHOT 6

QUALITY IMPROVEMENT – PLAN-DO-STUDY-ACT CYCLES 8

FINDINGS: SYSTEM INFRASTRUCTURE 9

PARTNER ABUSE PROGRAMME 9

CHILD ABUSE AND NEGLECT PROGRAMME 12

CULTURAL RESPONSIVENESS 15

FINDINGS: PROGRAMME INFORMATION 17

VIP IMPLEMENTATION WITHIN SERVICES 17

CAPACITY DEVELOPMENT (TRAINING) 17

ASSOCIATED VIP INITIATIVES 18

INTERNAL AUDIT OF CHILD, YOUTH & FAMILY REFERRALS 18

FINDINGS: SNAPSHOT 20

PARTNER ABUSE ASSESSMENT AND INTERVENTION 20

CHILD ABUSE & NEGLECT ASSESSMENT & INTERVENTION 34

ETHNICITY 37

FINDINGS: QUALITY IMPROVEMENT and PDSA CYCLES 38

DISCUSSION 41

REFERENCES 44

APPENDICES 41

APPENDIX A: Family Violence Programme Logic[a] 41

APPENDIX B: District Health Board Hospitals 42

APPENDIX C: VIP Snapshot Audit Information Sheet 57

APPENDIX D: DHB Self Audit Report: 2015 Follow-up Form 64

APPENDIX E: Delphi Scoring Weights 68

APPENDIX F: 2015 Audit Round Process 69

APPENDIX G: How to Interpret Box Plots 73

APPENDIX H. Partner Abuse Baseline and Follow-Up Scores 74

APPENDIX I: Partner Abuse Delphi Item Analysis 75

APPENDIX J. Child Abuse and Neglect Baseline and Follow-Up Scores 82

APPENDIX K. Revised Child Abuse and Neglect Delphi Tool Item Analysis 83

EXECUTIVE SUMMARY

The Ministry of Health (MOH) **Violence Intervention Programme** (VIP) seeks to reduce and prevent the health impacts of family violence and abuse through early identification, assessment and referral of victims presenting to designated District Health Board (DHB) services. The Ministry of Health-funded national resources support a comprehensive, systems approach to addressing family violence, particularly intimate partner violence (IPV) and child abuse and neglect (CAN).[1,2]

This report documents the results of four work streams for the 2015 VIP Programme Evaluation. These are: (1) DHB Delphi self audits of programme inputs (system infrastructure) assessed against criteria for an ideal programme; (2) VIP Snapshot clinical audits (outputs) in six services to measure programme service delivery; (3) assessment of VIP self audit findings and programme implementation within DHBs; and, (4) description of DHB submissions of Model for Improvement Plan-Do-Study-Act (PDSA) cycles.

This report provides Government, the Ministry, DHBs and service users with information and accountability data on family violence intervention programme implementation. VIP contributes towards the NZ Government's cross-government work programme to reduce family and sexual violence,[3] the NZ Government's Delivering Better Public Services, Supporting Vulnerable Children Result Action Plan,[4] and the Ministry's Statement of Intent 2014 to 2018.[5]

VIP Delphi Audits

Scaling up a quality, sustainable health response to family violence is reliant on quality systems.[6-12] DHBs reported achievement of IPV and CAN indicators for the period 1 July 2014 to 30 June 2015. Standardised Delphi audit scores may range from 0 to 100. The Ministry's minimal achievement threshold (target) for 2015 was a score ≥ 80.

Delphi Findings

The median DHB family violence infrastructure score was 92 for intimate partner abuse and 94 for child abuse and neglect programmes. With current resources, the overall median scores have been consistently high over four audit periods (Figure 1).

- *Overall child abuse and neglect programme scores ≥80 were achieved by all (n=20) DHBs.*
- *Overall partner abuse programme scores ≥80 were achieved by 95% (n=19) of DHBs.*

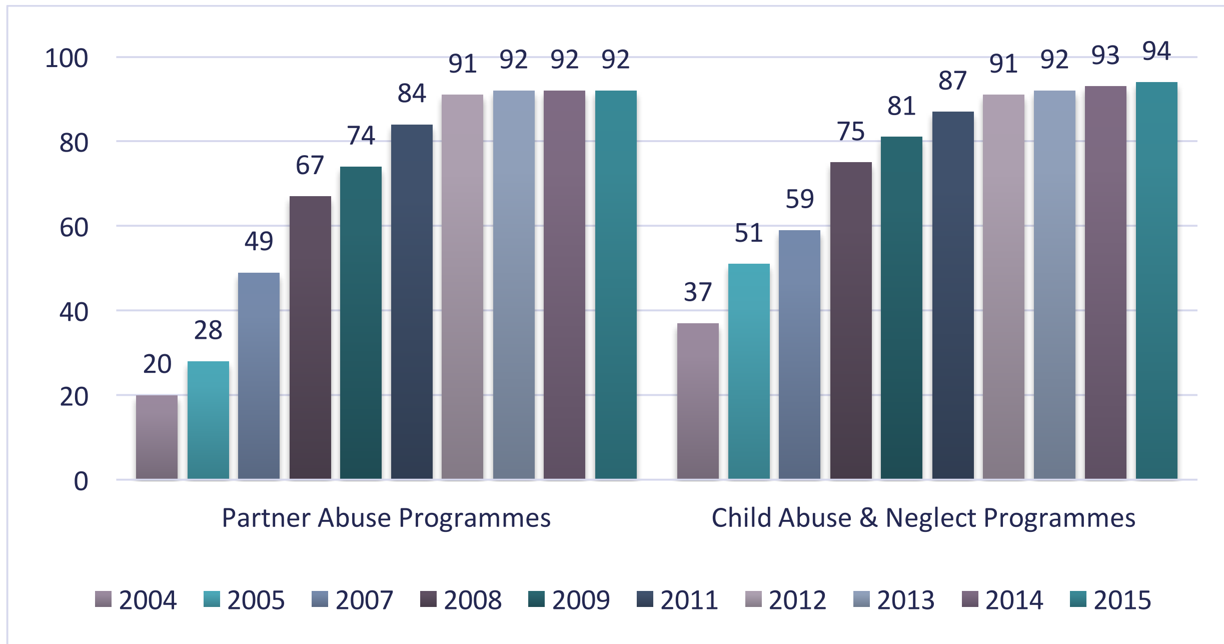


Figure 1. *Median Violence Intervention Programme (VIP) scores (2004-2015)*

While overall scores are high, there remains variation in programme domain scores. Among the 20 DHBS, one in three (35%, n=7) achieved scores greater than 80 across all partner abuse and child abuse and neglect domains. The *Evaluation Activities* domain scores, signalling internal programme monitoring, remain variable: 15 and 13 DHBs achieved an *Evaluation Activities* score ≥80 for partner abuse and child abuse and neglect programmes respectively.

Further system development is also needed for selected key indicators. For example, only 55% (n=11) of DHBs reported evaluating partner violence service effectiveness for Māori and 40% (n=8) of DHBs reported evaluating child abuse and neglect service effectiveness for Māori. This is a critical indicator to reduce health inequities. In addition, while all 20 DHBs have been approved to deliver the Ministry-approved standardised national VIP training package, the proportion of staff that have been trained varies across professions and services. And finally, while all DHBs reported VIP human resource, there is ongoing turnover of Family Violence Intervention Coordinators (FVICs), Child Protection Coordinators, their managers and VIP clinical champions. Fifty-five percent (n=11) of DHBs had at least one change in their VIP team in the one year audit period. This turnover, with associated periods with no incumbent, pose a significant risk for VIP quality and sustainability.

VIP Snapshot Clinical Audits

VIP Snapshot audits use a nationally standardised reporting process to monitor service delivery and inform performance improvements. They signal a programmatic focus on accountability, measurement and performance improvements[13] in the delivery of services for vulnerable children and their whānau and families. Snapshot audits allow pooling of DHB data to estimate (a) VIP output – women and children assessed for violence and abuse – as well as (b) VIP outcomes – women and children with a violence concern who received specialist assistance.

The inaugural IPV service delivery Snapshot clinical audits in 2014 included women (≥ 16 years) within two services (child health inpatient and postnatal maternity). An additional two services (emergency department and sexual health) were added in 2015. The CAN Snapshot clinical audits in 2014 and 2015 included assessment for children aged under two years presenting for any reason to emergency departments. Snapshot audits involve retrospective reviews of a random selection of clinical records from the three month period 1 April to 30 June.

In 2015 all DHBs were required to submit VIP Snapshot Audits in the five services listed above, whether or not they had implemented VIP in the service. This allowed national estimates of service delivery.

Snapshot clinical audit benchmarks have been identified:

- System reliability is achieved when a standard action occurs at least 80% of the time.[14] Therefore, the VIP aims to achieve IPV and CAN assessment rates ≥ 80%.
- The quality of IPV screening (routine inquiry) influences womens' decision whether or not to disclose IPV to a health worker.[15,16] The estimated New Zealand population past year IPV prevalence rate among women is ≈ 5%.[17,18] The prevalence of IPV reported by women receiving health care services is higher than the population prevalence in both international and New Zealand research.[19-23] This is not surprising given the negative impact of IPV on health.[24] The VIP expects IPV disclosure rates among women seeking health care to be ≥ 5%.
- Based on the prevalence of CAN indicators (such as CAN alerts), VIP expects the rate of child protection concern identification to be ≥ 5%.

Child Abuse and Neglect Snapshot Findings

- *Clinical assessment of children under two years of age presenting to an emergency department includes a child protection screen for approximately one of every four (26%).*
- *Specialist child abuse and neglect consultation occurs consistently (100%) when a child protection concern is identified.*

Table 1. *Emergency department population estimates of children under two years of age who received child abuse and neglect (CAN) assessment and service (April - June 2014 and 2015)*

	Children assessed for CAN indicators		CP Concern (≥1 positive indicator)		Specialist Consultation	
	2014	**2015**	**2014**	**2015**	**2014**	**2015**
Population estimate	4163	4242	549	374	489	374
Weighted mean	27%	26%	13%	9%	89%	100%
95% CI	20%, 34%	21%, 32%	8%, 18%	6%, 12%	*	*

Notes: proportion of child protection (CP) concern is among those who received a CAN assessment; proportion of specialist consultation is among those with an identified CP concern; confidence intervals not calculated for specialist consultation due to small numbers within individual DHBs. 20 DHBs (100%) undertook VIP CAN snapshot audits.

Intimate Partner Violence Snapshot Findings

- *Approximately one in every two women (48%) presenting to sexual health services are assessed for IPV.*
- *Approximately one in every two (48%) women admitted to postnatal maternity services are assessed for IPV (a significant increase from 33% in 2014.)*
- *For children admitted to child health inpatient services, approximately one of every three (35%) of their female caregivers are assessed for IPV.*
- *Approximately one in every four women (23%) presenting to emergency department services are assessed for IPV.*
- *The IPV disclosure rate among women in sexual health services (20%) is at least three times higher than the disclosure rate for women in postnatal maternity (4%), child health (4%) and emergency (6%) services.*

***Table 2**: Population estimates of women who received intimate partner violence (IPV) assessment and service (April - June 2014 and 2015)*

	Women screened		Disclosures		Referrals	
Service	**2014**	**2015**	**2014**	**2015**	**2014**	**2015**
Postnatal Maternity Inpatient						
Population estimate	2935	4,637	257	197	193	197
Weighted Mean	33%	48%	9%	4%	75%	100%
95% CI	26%, 39%	42%, 55%	3%, 14%	2%, 6%	*	*
Child Health Inpatient						
Population estimate	4869	4513	259	160	181	160
Weighted Mean	39%	35%	6%	4%	70%	100%
95% CI	31%, 48%	33%, 38%	4%, 9%	2%, 5%	*	*
Sexual Health						
Population estimate		2703		537		446
Weighted Mean		48%		20%		83%
95% CI		42%, 55%		13%, 27%		*
Emergency Department						
Population estimate		21,924		1310		982
Weighted Mean		23%		6%		75%
95% CI		20%, 26%		4%, 8%		*

Notes: Proportion of IPV disclosures is among those who were assessed for IPV; proportion of IPV referrals is among those who disclosed IPV; confidence intervals not calculated for referrals due to small numbers within individual DHBs. Sexual health and emergency department services not audited in 2014.

National estimates indicate that most women who received specialist family violence services in 2015 were referred through the emergency department (n=982) or sexual health (n=446). Both services had IPV disclosure rates greater than 5%; in addition, the emergency department has high patient volumes (Figure 2).

Average scores mask variability in service delivery. In 2015, there were seven service locations (included postnatal maternity or sexual health services within six DHBs) that achieved screening rates ≥ 80% and disclosures rates ≥ 5% (within the target zone)

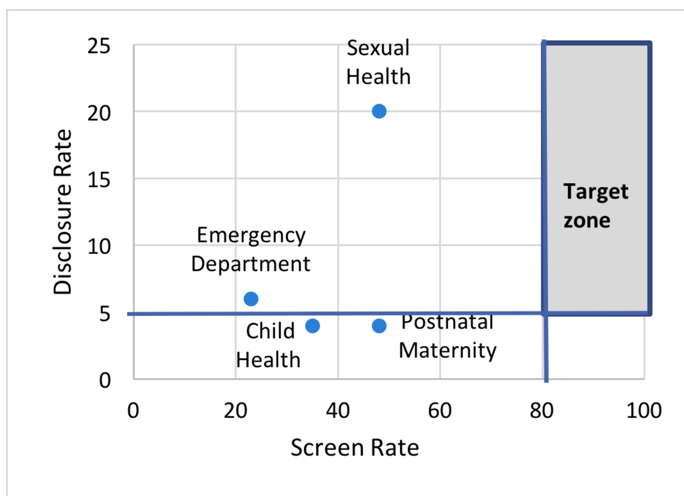


Figure 2. 2015 national average intimate partner violence Snapshot screening and disclosure rates.

VIP Implementation

Across Ministry of Health targeted services, in 2015, VIP services were being delivered in:

- 19 (95%) DHB Child Health inpatient services
- 19 (95%) DHB Postnatal Maternity inpatient services
- 19 (95%) DHB Emergency Departments
- 13 (65%) DHB Sexual Health community services
  - 2 (10%) DHBs have amalgamated their sexual health community services under a regional service
  - 3 (15%) DHBs fund NGOs to provide sexual health community services
  - 2 (10%) DHBs have not implemented VIP in sexual health community services

Quality Improvement Initiatives
Model for Improvement Plan-Do-Study-Act (PDSA)

In 2015, all DHBs were required to apply the Model for Improvement PDSA process[25] to improve the consistency and quality of their family violence service delivery response by submitting two PDSA plans. 2014 Snapshot results provided baseline data to focus 2015 programme improvement change efforts. Some submitted plans were complex and beyond the scope of a PDSA cycle. Several DHBs successfully applied the PDSA cycle to enhance performance.

Summary

VIP evaluation data provides important information about system inputs, outputs and outcomes. Clinical Snapshot audits promote programme accountability and can usefully direct national, DHB and service level improvements.

2015 data indicates that VIP is being successfully implemented in a small number of service locations in selected DHBS. Further improvements are needed to deliver a consistent, quality service nationwide to all vulnerable children, women and whānau/families experiencing violence in their everyday lives. Senior clinical leadership and quality improvement initiatives will continue to be a focus for the VIP programme in the foreseeable future.

INTRODUCTION

Internationally and within New Zealand, family violence is acknowledged as a preventable public health problem and human rights violation that impacts significantly on women, children, whānau and communities.[10,26-29] Early identification of people subjected to violence followed by a supportive and effective response can improve safety and wellbeing.[10] The health care system is an important point of entry for the multi-sectoral response to family violence, including both preventing violence and treating its consequences.

The Ministry of Health ('the Ministry') began the Family Violence Health Intervention Project in 2001 (see Appendix A) and launched the renamed Violence Intervention Programme (VIP) in 2007. VIP seeks to reduce and prevent the health impacts of violence and abuse through early identification, assessment and referral of victims presenting to health services. This programme provides the infrastructure for the health sector response, which is one component of the multi-agency approach to reduce family violence in New Zealand led by the Ministerial Group on Family Violence and Sexual Violence.[3] The Violence Intervention Programme is strategically aligned with the NZ Government's Delivering Better Public Services, Supporting Vulnerable Children Result Action Plan,[4] and the Ministry's Statement of Intent 2014 to 2018.[5] The Better Public Services Target specifies, "By 2017, we aim to halt the rise in children experiencing physical abuse and reduce current numbers by 5 per cent".[4] This target is based on Child, Youth and Family substantiated cases of physical abuse. Two Violence Intervention Programme outputs of interest linked to this target include the proportion of children seen in the emergency department with evidence of a child protection assessment and initiation of collaboration with Child, Youth and Family when risk indicators are present.

VIP in DHBs is premised on a standardised, comprehensive systems approach[10-12,30] supported by six programme components funded by the Ministry (Figure 3). These components include:

- District Health Board Family Violence Intervention Coordinators (FVIC).
- Ministry of Health Family Violence Intervention Guidelines: Child and Partner Abuse (2002[1], 2016[2]).
- Resources that include a Ministry Family Violence website, a VIP section on the Health Improvement and Innovation Resource Centre (HIIRC) website, posters, cue cards, pamphlets and the VIP Quality Improvement Toolkit.
- Technical Advice and support provided by a National VIP Manager for DHBs, National VIP Trainer and national and regional Family Violence Intervention Coordinator networking meetings.
- National training contracts for DHB staff, midwives and primary care providers.
- Monitoring and evaluation of DHB family violence responsiveness.

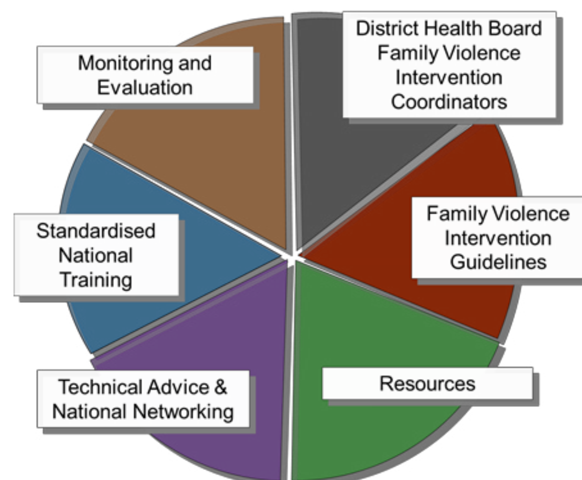


Figure 3: *Ministry of Health VIP Systems Support Model (DHBs)*

This report documents the results of four evaluation work streams. **Firstly**, DHB programme inputs (system infrastructure) are assessed at the DHB level against criteria for an ideal programme using Delphi tools.[31-33] The quantitative Delphi scores provide a means of monitoring infrastructure across the 20 New Zealand DHBs over time. This work stream has led to important national initiatives directing programme funding, development of the VIP Quality Improvement Toolkit, Model for Improvement workshops and a Whānau-Centred resource.[34] **Secondly,** programme service delivery is measured by VIP Snapshot clinical audits. Snapshot audits conducted in New South Wales have proved useful in monitoring

service delivery.[35] Snapshot clinical audits measure women and children assessed for violence and abuse and women and children with a violence concern who receive specialist assistance. The Snapshots provide accountability data and the inaugural audits in 2014 serve as baseline for monitoring the effect of system changes. **Thirdly**, programme implementation is assessed by collating and analysing DHB submitted information regarding VIP self audit findings and observations within each DHB including significant achievements, programme strengths, areas for improvement and roll out across services. **Lastly**, for the first time in 2015, Model for Improvement Plan-Do-Study-Act (PDSAs)[25] became part of the evaluation process as a quality improvement initiative. DHBs complete two PDSAs focused on improving DHB IPV screening (routine enquiry) and disclosure rates or CAN child protection assessment and concern rates.

This evaluation report provides practice-based evidence of the current violence intervention programme inputs, outputs and outcomes (Figure 4). Together, the Delphi infrastructure, programme information and Snapshot audits deliver data to the Ministry of Health, the VIP National Management Team and other key government departments involved in strategies, resourcing and developments, to reduce the rate of child abuse and neglect and partner abuse experienced within New Zealand families and whānau. It also contributes to the whole of government priorities on protecting vulnerable children[36] and Whānau Ora.[37]

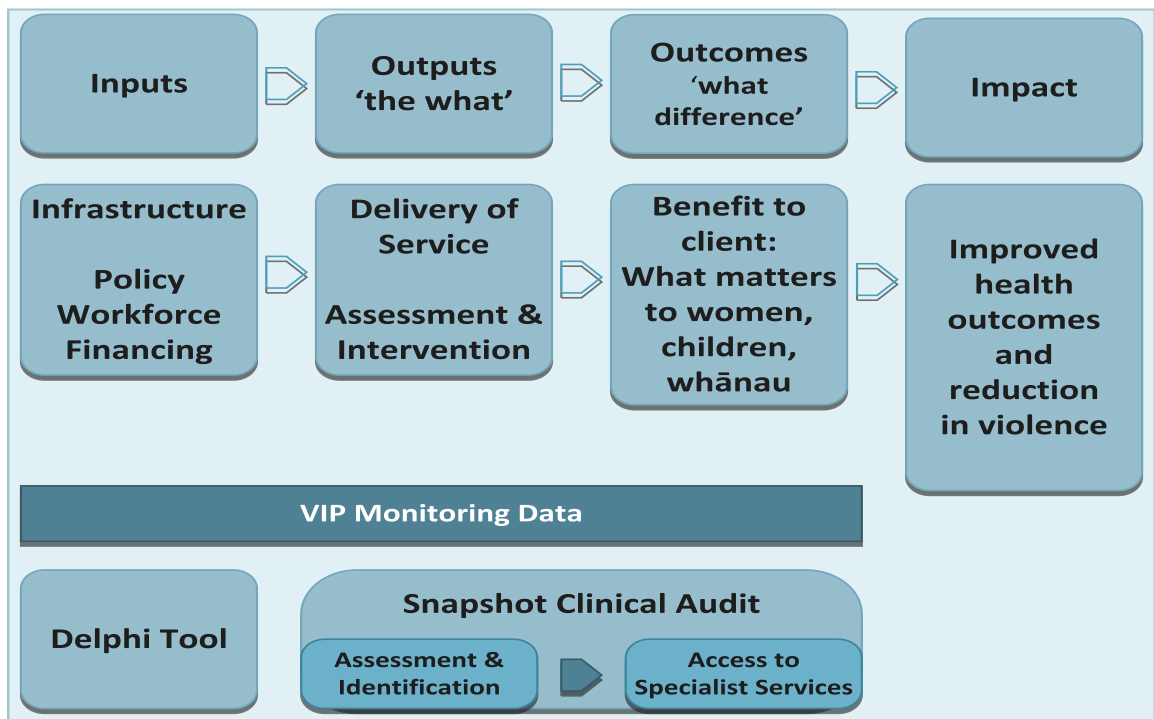


Figure 4: *VIP Evaluation Monitoring Data Sources*

The Violence Intervention Programme evaluation in 2015 aimed to (a) measure service delivery consistency and quality in Ministry of Health targeted services and (b) foster system improvements.

METHODS

Participation in the evaluation process was specified in Ministry of Health VIP contracts with DHBs. All 20 New Zealand DHBs participated (see Appendix B). The evaluation project was approved by the Multi-region Ethics Committee (AKY/03/09/218 with annual renewal up to 5/12/17).

Evaluation procedures were conducted based on a philosophy of supporting programme leaders in building a culture of improvement.[25,38] Details of the 2015 evaluation processes are outlined in Figure 5 and Appendix C and D. The process began on 29 September 2015 with a letter from the Ministry advising DHBs of the upcoming 2015 audit round.

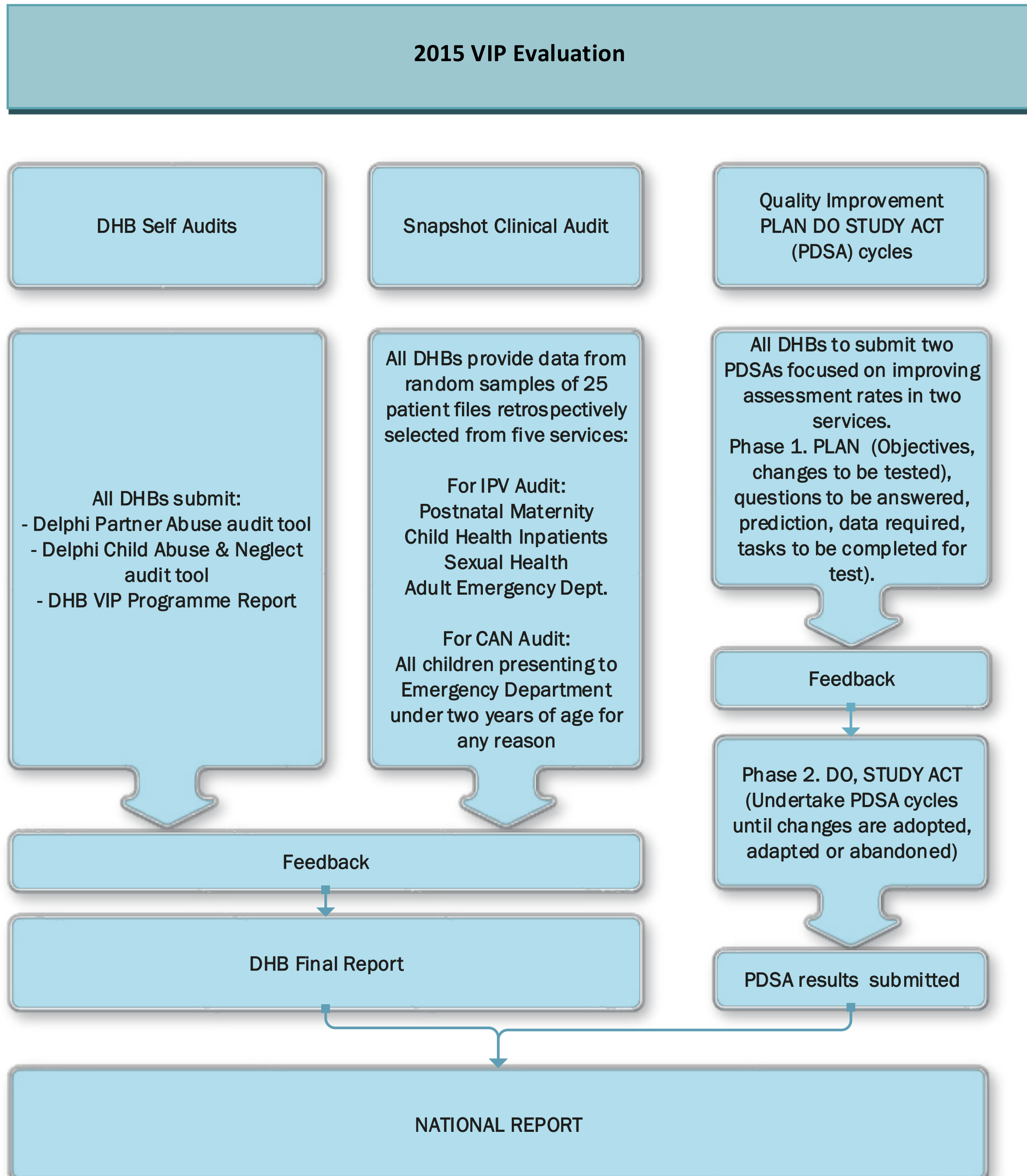


Figure 5. 2015 Evaluation Plan

SYSTEM INFRASTRUCTURE (DELPHI AUDIT)

DHBs were invited to submit self audit data by 28 October 2015, for the audit period 1 July 2014 to 30 June 2015. The 2015 audit was the tenth audit measuring system development since 2003. Requested documentation included:

1. Partner Abuse Audit Tool (see following section)
2. Child Abuse and Neglect Audit Tool (see following section)
3. Self-Audit Report 2015 (including VIP Implementation status, self audit findings and observations (e.g. most significant VIP achievements, programme strengths, areas for improvement.

PA & CAN Programme Evaluation Audit Tools

Quantitative self audit data were collected applying the *Partner Abuse (PA) Programme Evaluation Tool* and *Child Abuse and Neglect (CAN) Programme Evaluation Tool*. These tools reflect modifications of the *Delphi Instrument for Hospital-Based Domestic Violence Programme*[33,39,40] for the bicultural Aotearoa New Zealand context. The audit tools assess programmes against criteria for an ideal programme.

The Partner Abuse (*PA) Tool* has been used without change across all audit periods. In 2007, a Delphi process with a New Zealand expert panel was conducted to revise the Child Abuse and Neglect (*CAN) Tool* to improve its content validity.[31] This *Revised CAN Tool* has been used since the 48 month follow-up audit.[41] The audit tools are available (open access at www.aut.ac.nz/vipevaluation) as interactive Excel files, allowing users to see measurement notes, enter their indicator data and be provided score results.

The 64 performance measures in the *Revised CAN Tool* and 127 performance measures in the *PA Tool* are categorized into domains reflecting components consistent with a systems model approach (see Figure 6). Each domain score is standardised resulting in a possible score from 0 to 100, with higher scores indicating greater levels of programme development. An overall score is generated using a weighting scheme (see Appendix E). The Ministry's minimal achievement threshold (target score) was raised from 70 to 80 for the 2015 audit.

Domain	Description
Policies and Procedures	• Policies and procedures outline assessment and treatment of victims: mandate identifcation training; and direct sustainability
Safety and Security	• Children and young people are assessed for safety, safety risks are identified and securities plans implemented [CAN tool only]
Physical Environment	• Posters and brochures let patients and visitors know it is OK to talk about and seek help for family violence
Institutional Culture	• Family violence is recognised as an important issue for the health organisation
Training of Providers	• Staff receive core and refresher training to identify and respond to family violence based on a training plan
Screening & Safety Assessment	• Standardised screening and safety assessments are performed [PA tool only]
Documentation	• Standardised family violence documentation forms are available
Intervention Services	• Checklists guide intervention and access to advocacy services
Evaluation Activities	• Activities monitor programme efficiency and whether goals are achieved
Collaboration	• Internal and independent collaborators are involved across programme processes

Figure 6. Audit Tool Domains

Recognising that culturally responsive health systems contribute to reducing health inequalities, indicators addressing Māori, Non-Māori non-Pakeha (e.g. Pacific Island, Asian, migrant and refugee) and general cultural issues for planning and implementing a family violence response in the health sector have been integrated within the Partner Abuse (n=30 items) and Child Abuse and Neglect (n=28 items) audit tools. These items contribute to a *Cultural Responsiveness* score, standardised to range from 0 to 100.

Procedure

All (n=20) DHBs undertook self audits in the 2015 programme evaluation. The Ministry advised all DHBs on 29 August 2015 that the audit was to commence and on 1 September 2015 audit documentation (including evaluation resources) was distributed by the AUT Evaluation Team.

DHBs submitted their completed electronic Delphi files to the independent evaluation team. Following review of data and documentation, the evaluation team provided feedback to the DHB CEO, copied to the DHB VIP portfolio manager, FVICs and the Ministry.

Analysis

Self audit data were exported from Excel audit tools into an SPSS Statistics (Version 22) file. Score calculations were confirmed between Excel and SPSS files. In this report we present overall Delphi and domain scores covering 10 audits from 2004 to 2015. Box plots and league tables are used to examine the distribution of scores over time (see Appendix F: *How to Interpret Box Plots*). The unit of analysis for the infrastructure (Delphi Tool) analysis was hospital until 2011. From 2012 onwards the unit of analysis has been DHB. The change to analysis by DHB was implemented due to a lack of infrastructure variation within DHBs and recognising that programme management (and reporting to the Ministry) occurs by DHB. As individual extreme scores influence mean scores, we favour reporting medians (and box plots).

PROGRAMME INFORMATION

VIP programme information is collected as part of the DHB self audit process (Appendix D). It allows DHBs to summarise their programme progress since the previous audit and to identify VIP service implementation, programme strengths and challenges. Programme information assists the national VIP management team to monitor programme implementation. Services are considered to have implemented VIP when service level protocols and training have been instituted within the service.

The Self Audit Report also includes supplementary information about cultural responsiveness to Māori, Elder Abuse and Neglect policies, disability initiatives, Shaken Baby Programme implementation and internal clinical audit summaries based on the VIP Quality Improvement Toolkit. In 2015 we focused on documentation standards when a referral is made to Child, Youth and Family. This included review of clinical records and Reports of Concern (ROC). Quantitative programme information was entered into an SPSS file for descriptive analysis. Data on training is also included. Training is a necessary, though insufficient, pre-requisite to support a sensitive, quality response to family violence. DHBs were asked to report the proportion of staff (e.g. doctors, nurses, midwives, social workers) in designated services who have received the national VIP training.

SNAPSHOT

The Snapshot clinical audits aim to collect "accountability data that matter to external parties"[13] and use a nationally standardised reporting process to monitor service delivery and inform performance improvements.[42]

Snapshot audits provide estimates of: (a) VIP outputs – women and children assessed for violence and abuse, and (b) VIP outcomes – women and children with a violence concern who received specialist assistance. The inaugural VIP Snapshots occurred in 2014 with two new services added for the 2015 Evaluation.

Benchmarking

Snapshot audits provide assessment of comparability and a process to foster the implementation of best practice.

- System reliability is achieved when a standard action occurs at least 80% of the time.[14] Therefore, the VIP aims to achieve IPV and CAN assessment rates ≥ 80%.
- The quality of IPV screening (routine inquiry) influences women's decision whether or not to disclose IPV to a health worker.[15,16] The estimated New Zealand population past year IPV prevalence rate among women is ≈ 5%.[17,18] The prevalence of IPV reported by women receiving health care services is higher than the population prevalence in both international and New Zealand research.[19-23] This is not surprising given the negative impact of IPV on health.[24] The VIP expects IPV disclosure rates among women seeking health care to be ≥ 5%.
- Based on the prevalence of CAN indicators (such as CAN alerts), VIP expects the rate of child protection concern identification to be ≥ 5%.

Selected Services

For the 2015 Snapshot audit, five services were audited.

Intimate Partner Violence Clinical Audit:

- **Postnatal Maternity** inpatient
- **Child Health** inpatient (Female guardians, parents or care givers assessed for partner abuse)
- **Sexual Health** (inaugural audit)
- **Emergency Department** [adult] (inaugural audit)

Child Abuse & Neglect Clinical Audit:

- **Emergency Department** [children] children under two years of age presenting for any reason

Sampling and Eligibility

Within each DHB, for each selected service, a random sample of 25 eligible records during the three month audit period (**1 April – 30 June 2015**) were retrospectively reviewed by DHB VIP staff or delegates. Therefore, the Snapshot involved each DHB reviewing a total of 125 clinical records.

DHBs sampled main sites (e.g., secondary or tertiary hospitals, or community). DHBs were instructed to seek assistance with selecting a random sample from their Quality Manager, Clinical Records or information specialists. The VIP Tool Kit also includes a document entitled "How to select an audit sample".

Eligibility criteria were (see also Appendix C):

- **Postnatal Maternity –** any woman who has given live birth and been admitted to postnatal maternity ward during the audit period
- **Child Health Inpatient** – the female caregiver (guardian, parent or caregiver) of any child aged 16 and under admitted to a general paediatric inpatient ward (not a specialty setting) during the audit period
- **Sexual Health Services** – all women aged 16 years and over who present to sexual health services during the audit period
- **Emergency Department [adult]** – all women aged 16 years and over who present to an emergency department during the audit period
- **Emergency Department [children]**- all children under the age of two years who present to an emergency department (for any reason) during the audit period

Data Elements

The following variables were collected for each randomly selected case (see definitions in Appendix C):

- DHB, site, and service
- Total number of eligible patients (women, or child – depending on service) in the designated service during the three month audit period 1 April 2015 to 30 June 2015.
- Ethnicity of patient. Up to three ethnicities per patient were able to be recorded.
- Child's Age (ranging between 0 – 16 years) for child health inpatient service only.
- Partner Abuse variables:
    - IPV screen (yes or no)
    - IPV disclosure (yes or no)
    - IPV referral (active (onsite), passive (offsite) or none).
- Child Abuse and Neglect variables:
    - Child Protection/Risk Assessment (yes or no)
    - Child Protection Concern identified (yes or no)
    - Child Protection consultation (yes or no).

Analysis

Snapshot data were exported from the secure web-based server in an excel file and imported into SPSS Statistics (Version 22). Descriptive analysis was conducted for each data element (see prior section). For reporting ethnicity, consistent with Ministry of Health standard,[43] where more than one ethnic group is recorded, the person was counted in each applicable group.

For each service, a national mean screening rate and 95% confidence intervals were derived from individual DHB screening rates weighted by the number of clients seen per DHB during the period. Data were then extrapolated to provide national estimates of the number of health clients seeking care within the designated services during the audit period who received VIP services. The disclosure and referral rates were calculated similarly.

The electronic VIP Snapshot reporting system provides service results and a graph on completion of the input for each service. The VIP National team received the results of the VIP Snapshot audits in February 2016. Individual audit results were provided to the DHB Portfolio Manager, copied to the Line Manager, FVI Coordinator and the Ministry in July 2016.

QUALITY IMPROVEMENT – PLAN-DO-STUDY-ACT CYCLES

The Model for Improvement Plan-Do-Study-Act (PDSA) cycle was introduced into the quality and evaluation activities of the VIP Programme in 2015.

The Model for Improvement[25] is a simple framework to guide specific improvements in personal work, teams or natural work groups. The model comprises three basic questions: What are we trying to accomplish; How will we know that a change is an improvement; and What Change can we make that will result in an improvement. The fourth element of the model uses the Plan-Do-Study-Act cycle for testing the change or innovation on a small scale to see if it will result in an improvement. An essential component of developing a PDSA is the making of a prediction about what will happen during the PDSA cycle. Prediction combined with the learning cycle reveals gaps in knowledge and provides a starting place for growth. Without it learning is accidental at best, but with it, efforts can be directed toward building a more complete picture of how things work in the system.

Two PDSA Plans were requested to be submitted for approval by the AUT Evaluation Team prior to implementation (i.e. writing up the PLAN phase before undertaking the DO, STUDY, and ACT phases of the PDSA cycle). They were directed to be aimed at improving service delivery using their 2014 Snapshot results as a baseline. PDSA cycles were to improve rates of family violence assessment or specialised consultation, or cultural responsiveness for Māori. A PDSA pack (including a template, resource and instructions) was distributed and ongoing support, coaching and feedback was provided by the Evaluation Team.

DHBs that achieved improvements in 2015 were invited to outline key factors that contributed to their achievements for system learning. Their stories are included in this report (within Boxes).

FINDINGS: SYSTEM INFRASTRUCTURE

PARTNER ABUSE PROGRAMME

With current resources, the overall partner abuse programme median infrastructure scores have been consistently high over four audit periods (Figure 7 and Appendix I).

- The 2015 median partner abuse programme score was 92.
- Partner abuse programme scores > 80 were achieved by 95% (n=19) of DHBs.

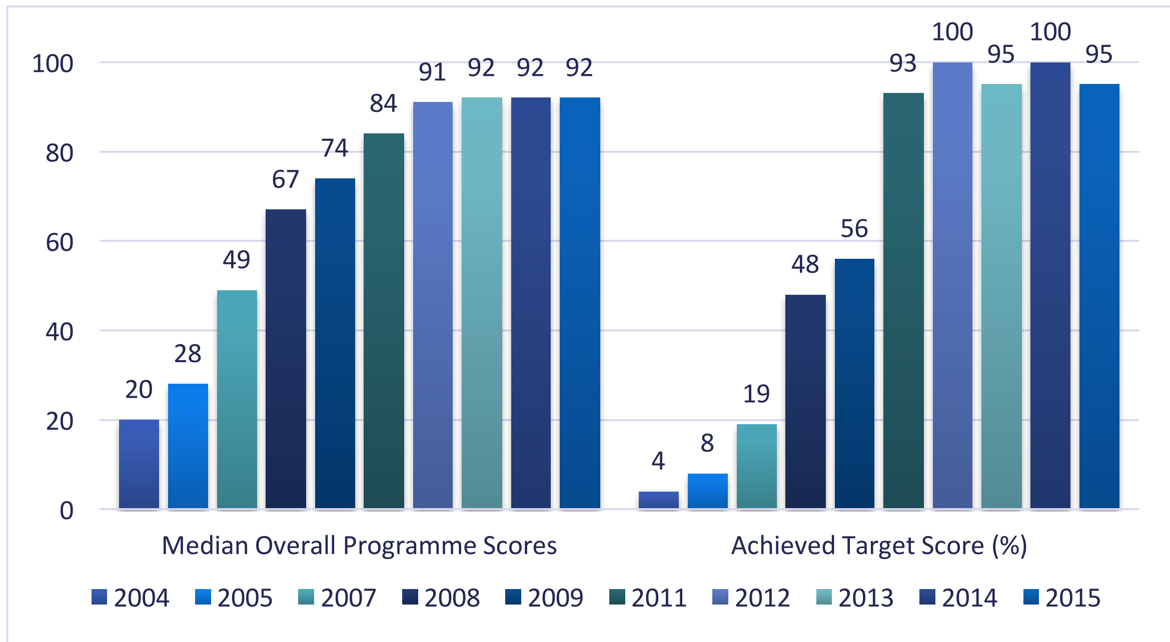


Figure 7. Partner Abuse Violence Intervention Programme Scores 2004-2015

Figure note: The Ministry of Health minimal achievement threshold (target score) was raised from 70 to 80 for the 2015 audit.

Variability in scores over time is shown in Figure 8. Since the 84 month follow up audit, scores have been consistently at the higher range of the scale. In 2015 the partner abuse score ranged from 76 to 99; the standard deviation was 5.79.

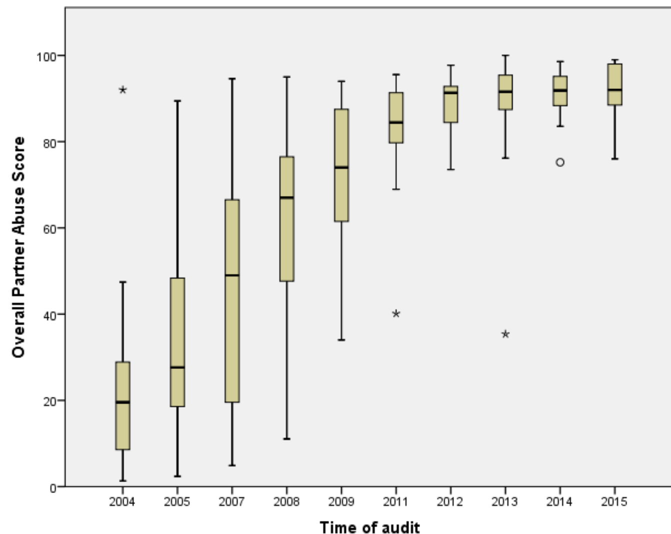


Figure 8. Overall partner abuse score distribution over time.

Partner Abuse Programme Indicators

Many indicators of a systems approach for responding to partner abuse are in place across all 20 DHBs. Selected partner abuse programme indicators are highlighted below. Frequencies for individual partner abuse programme tool indicators are provided in Appendix I.

100% (n=20) of DHBs had one or more dedicated FVI coordinator position at the time of the audit. However, 55% (n=11) of DHBs had at least one change in their VIP team in the one year audit period.

On-site victim advocacy services are provided:

- *At all times by 80% (n=16) of DHBs*
- *During certain times by 20% (n=4) of DHBs*

65% (n=13) of DHBs routinely offer patients with injuries an option to have their injuries photographed; 65% (n=13) also provide staff training in forensic photography.

80% (n=16) of DHBs have an Employee Assistance Programme (or similar) that maintains specific policies and procedures for responding to employees experiencing partner abuse.

75% (n=15) of DHBs measure community satisfaction with the partner abuse programme, such as by Refuge service and Police. Few DHBs, however, include gathering client satisfaction data, necessary to advancing client[40] and whānau-centred care.[22]

Partner Abuse Programme Domains

- All nine partner abuse programme domain median scores exceeded the target score of 80 (Table 3).
- Only half of New Zealand DHBs (n=10) achieved the target score (≥80) across all nine domains.
- Twenty-five percent (n=5) of DHBs scored less than 80 in the *Evaluation Activities* domain.

Table 3. *2015 Partner Abuse Domain results (N=20 DHBs)*

Domain	Median Score	Minimum score	Maximum score	No. DHBs below target (< 80)
Policies & Procedures	90	76	100	2
Physical Environment	100	70	100	3
Cultural Environment	94	67	100	3
Training of Providers	100	78	100	1
Screening & Safety Assessment	93	66	100	1
Documentation	95	62	100	4
Intervention Services	97	76	100	1
Evaluation Activities	92	14	100	5
Collaboration	100	92	100	0

Partner Abuse Programme League Tables

The DHB league table for the 2015 partner abuse intervention programme score is presented in Table 4. The amount of change since the last audit (absolute score difference) ranged from a decrease of 17 to an increase of 17.

Scores in the league table reflect infrastructure development rather than diffusion across or within services. There remains variation in individual DHB scores over time. Anecdotally, explanations for score improvements include increased political will by senior DHB executive, consistency in VIP managers and coordinators, programme reviews and service innovations.

***Table 4**. DHB Partner abuse programme scores: League Table (2014 – 2015)*

Rank	DHB	2015	2014	Change from 2014
1	Northland	99	96	3
2	Bay of Plenty	99	99	0
3	Waikato	99	98	1
4	Counties Manukau	98	98	0
5	Mid Central	98	95	3
6	Lakes	96	92	4
7	Taranaki	94	92	2
8	Canterbury	93	93	0
9	Capital & Coast	92	75	17
10	Southern	92	95	-3
11	Hutt Valley	92	87	5
12	West Coast	91	90	1
13	South Canterbury	90	90	0
14	Whanganui	89	89	0
15	Wairarapa	89	91	-2
16	Nelson Marlborough	88	84	4
17	Tairawhiti	86	92	-6
18	Auckland	86	88	-2
19	Hawkes Bay	85	85	0
20	Waitemata	76	93	-17
	DHB Median	**92**	**92**	**0**

CHILD ABUSE AND NEGLECT PROGRAMME

With current resources, the overall child abuse and neglect programme median infrastructure scores have been consistently high over four audit periods (Figure 9 and Appendix J).

- The 2015 median child abuse and neglect score was 94.
- Child abuse and neglect programme scores > 80 were achieved by all DHBs.

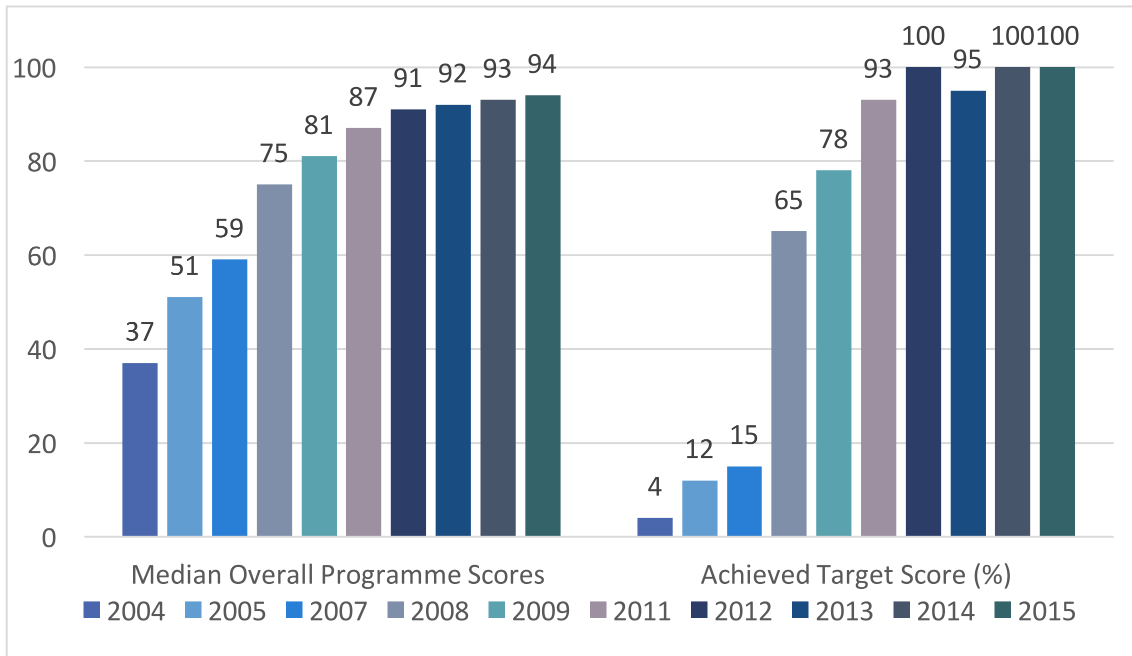


Figure 9. Child Abuse and Neglect Programme Scores (2004-2015)

Accompanying higher scores over time has seen less score variation (Figure 10). The 2015 child abuse and neglect score ranged from 76 to 99; the standard deviation was 4.88.

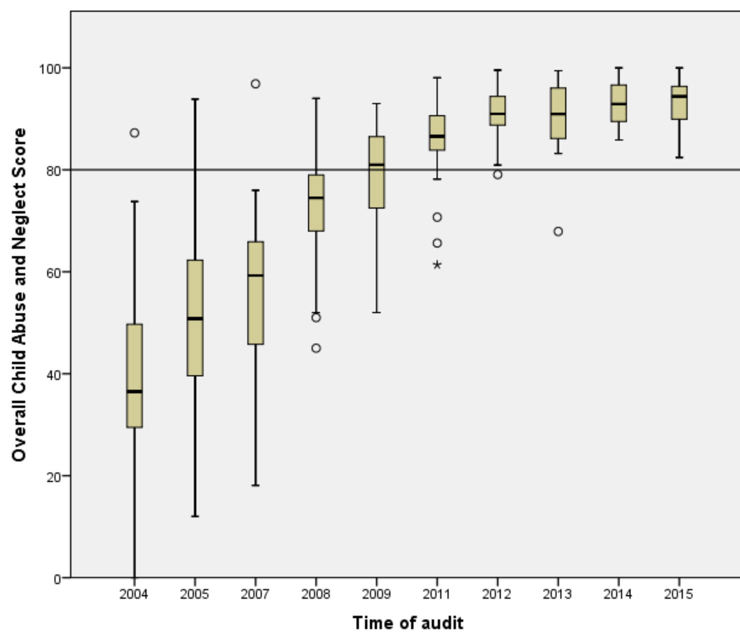


Figure 10. DHB Overall Child Abuse and Neglect Score Distributions over Time.

Child Abuse and Neglect Programme Indicators

Most indicators of a systems approach for responding to child abuse and neglect are in place across all DHBs. Selected child abuse and neglect programme indicators are highlighted below. Frequencies for all child abuse and neglect programme indicators are provided in Appendix K.

All DHBs have a clinical assessment policy for identifying signs and symptoms of child abuse and neglect and for identifying children at risk.

All DHBs collaborate with Child, Youth and Family and the Police in programme planning and safety planning for children at risk.

95% (n=19) of DHBs had been approved for the National Child Protection Alert Systems (NCPAS)

80% (n= 16) of DHBs record, collate and report on data related to child abuse & neglect assessments, identifications, referrals and alert status to senior management; 75% (n=15) of DHBs monitor demographics, risk factors and types of abuse trends.

55% (n=11) of DHBs have a full time (≥ 1FTE) child protection coordinator resource.

50% (n=10) of DHBs have social workers available 24/7 (either on site or on call).

Child Abuse & Neglect Programme Domains

- All nine child abuse and neglect programme domain median scores exceeded the target score of 80 (Table 5).
- Sixty percent (n=12) of New Zealand DHBs achieved the target score (≥80) across all nine domains.
- One in three (35%, n=7) DHBs scored less than 80 in the *Evaluation Activities* domain.
- One in three (35%, n=7) DHBs achieved scores greater than 80 across all partner abuse and child abuse and neglect domains.

***Table 5**. 2015* Child Abuse and Neglect Domain results (N=20 DHBs)

Domain	Median Score	Minimum Score	Maximum Score	No. DHBs below target (<80)
Policies and Procedures	96	80	100	0
Safety and Security	100	80	100	0
Collaboration	100	83	100	0
Institutional Culture	96	77	100	1
Training of Providers	99	90	100	0
Intervention Services	91	82	100	0
Documentation	100	67	100	2
Evaluation Activities	82	26	100	7
Physical Environment	96	79	100	2

Child Abuse and Neglect Programme League Tables

The DHB league table for the 2015 child abuse and neglect intervention programme scores is presented in Table 6. The amount of change since the last audit (absolute score difference) ranged from a decrease of 17 to an increase of 6.

Scores in the league table reflect infrastructure development rather than diffusion across or within services. While most DHBs are maintaining high scores over time, there remains variation. Anecdotally, explanations for score improvements include increased political will by senior DHB executive, consistency in VIP managers and child protection coordinators, programme reviews and service innovations.

Table 6. Child Abuse and Neglect programme scores: DHB League Table (2014-2015)

Rank	DHB	2015	2014	Change from 2014
1	Bay of Plenty	100	100	0
2	Counties Manukau	99	99	1
3	Northland	98	96	2
4	Canterbury	97	97	0
5	Taranaki	96	92	4
6	Lakes	96	93	4
7	Mid Central	96	95	1
8	Auckland	95	98	-2
9	Waikato	95	94	1
10	South Canterbury	95	94	0
11	Capital & Coast	94	88	6
12	Nelson Marlborough	93	90	3
13	West Coast	92	88	4
14	Wairarapa	92	93	-1
15	Hutt Valley	90	88	2
16	Southern	90	89	0
17	Whanganui	88	90	-1
18	Hawkes Bay	86	86	0
19	Tairawhiti	84	92	-7
20	Waitemata	82	99	-17
	DHB Median	**94**	**93**	**1**

CULTURAL RESPONSIVENESS

VIP recognises culturally responsive health systems contribute to reducing health inequalities. The following Figure (Figure 11) summarises the sub-set of audit tool indicators (30 indicators for partner abuse and 28 for child abuse and neglect) evaluating cultural responsiveness within VIP programmes across the nine evaluation periods.

- The typical (median) overall *Cultural Responsiveness* scores have been maintained at or above 90 for three audit periods.

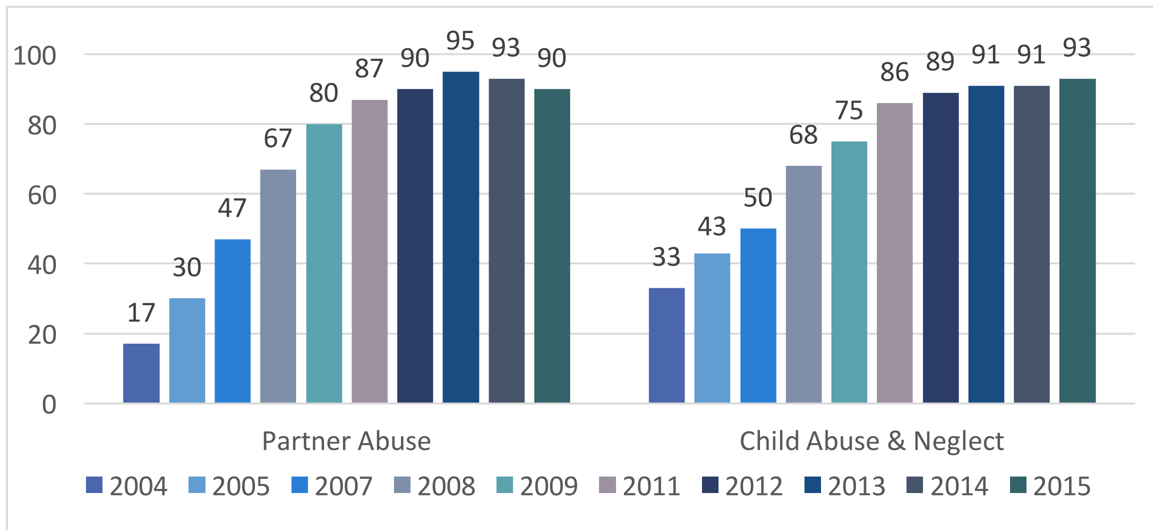


Figure 11. Median VIP Cultural Responsiveness Scores 2004-2015

All (n=20) DHBs have a protocol for collaborative safety planning for children at high risk with Māori and Pacific Health providers.

95% of DHBs collaborate with Māori community organisations and providers to deliver preventive outreach and public education activities.

Despite overall high median cultural responsiveness scores and many achieved cultural indicators, some key indicators remain absent in many DHBs (Figure 12). For instance:

- 55% (n=11) of DHBs use a quality framework to evaluate whether partner abuse services are effective for Māori.
- 40% (n=8) of DHBs use a quality framework to evaluate whether child abuse and neglect services are effective for Māori.

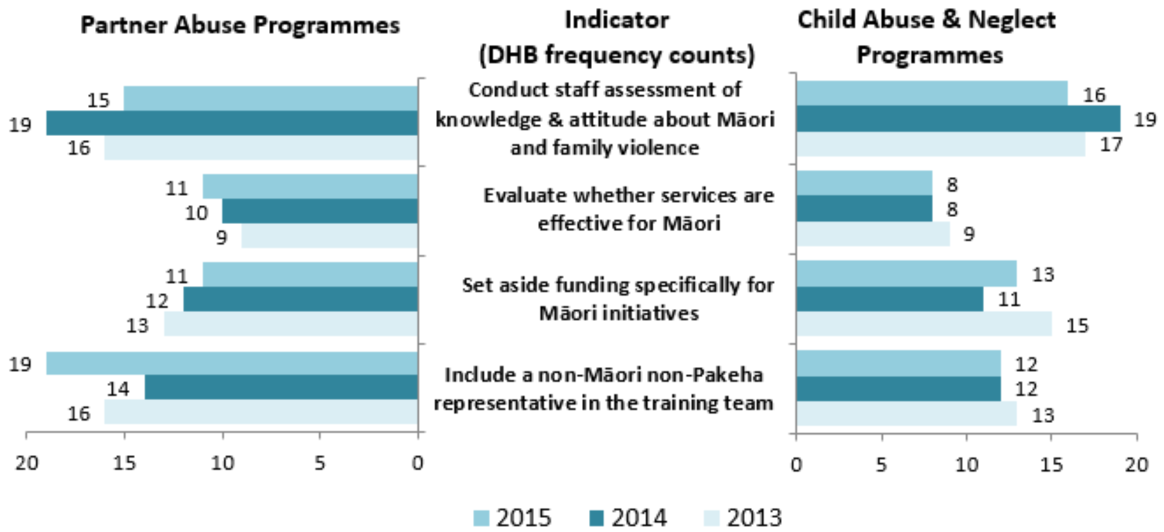


Figure 12. Selected Cultural Responsiveness Indicators (n=20 DHBs)

FINDINGS: PROGRAMME INFORMATION

VIP IMPLEMENTATION WITHIN SERVICES

VIP continued to be rolled out in Ministry of Health targeted services in 2015 (Figure 13). Nineteen of twenty DHBs have implemented VIP in child health inpatient, emergency department and postnatal maternity inpatient services. Thirteen of fifteen sexual health services (offered regionally in some locations) have implemented VIP. Some DHBs have reported implementing VIP in services beyond the Ministry targeted services (such as in medical wards and primary health care services).

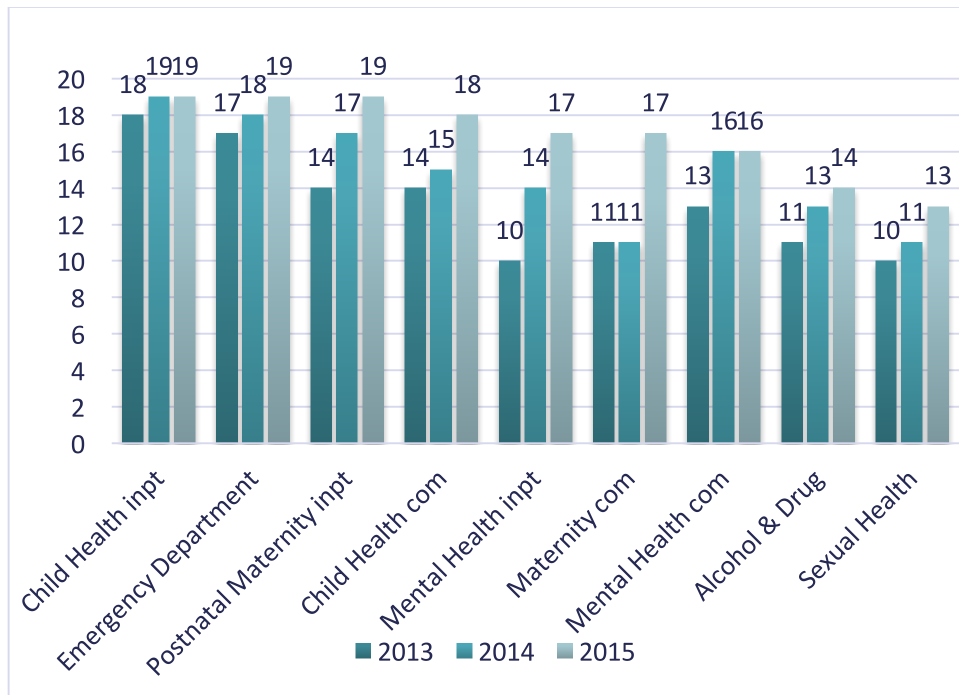


Figure 13. VIP Implementation by Service (number of DHBs)

Figure Notes: inpt=inpatient service; com=community service; there are 15 Sexual Health Services and 17 Alcohol & Drug Services nationally. Some Alcohol & Drug services have been amalgamated within Community Mental Health.

CAPACITY DEVELOPMENT (TRAINING)

Only eight DHBs (an increase from four DHBs in 2014) were able to provide training data for all implementing services (though not necessarily for all professions). Among reporting DHBs, training varied widely among health provider profession and among services (Table 9). The lower participation of physicians in VIP training (with the exception of sexual health services) evidences a capacity gap in the interprofessional health delivery team.

Table 9: DHBs reporting proportion of staff who had received national VIP training

Emergency Department				
	Doctors	Social Workers	Nurses	Midwives
No. DHB reporting	8	8	9	N/A
% trained	0%-60%	0%-100%	10%-100%	
Median	0%	100%	85%	
Postnatal Maternity				
No. DHB reporting	5	8	5	9
% trained	0%-60%	100%	90%-100%	30-100%
Median	0%	100%	100%	81%
Child Health Inpatients				
No. DHB reporting	7	7	10	N/A
% trained	0-100%	30%-100%	5%-100%	
Median	10%	100%	93%	
Sexual Health				
No. DHB reporting	7	5	9	N/A
% trained	0%-100%	0%-100%	7%-100%	
Median	90%	100%	100%	
Emergency Department [Children under 2]				
No. DHB reporting	6	9	9	N/A
% trained	0%-90%	30%-100%	49% - 100%	
Median	0%	100%	90%	

Notes: The number of DHBs reporting emergency department training is variable for adult and children as there are some child specific emergency services (e.g., Kidz First, Starship).

ASSOCIATED VIP INITIATIVES

New initiatives linked to VIP included the Shaken Baby programme, Elder Abuse Intervention policies and implementation, and the development of policies to address issues for persons with disabilities who are abused.

All 20 (100%) DHBs had implemented Shaken Baby Programme.

70% (n=14) of DHBs had approved and implemented Elder Abuse policies.

75% (n=15) of DHBs had policies to address issues for persons with disabilities.

INTERNAL AUDIT OF CHILD, YOUTH & FAMILY REFERRALS

Sixteen DHBs (80%) provided internal audit data for Reports of Concern to Child, Youth and Family and their accompanying clinical records. The period of review varied across the reporting DHBs, from 1 to 12 months. The number of cases reviewed ranged from 3 to 303, representing between 10% and 100% of eligible cases during the review period. Among reporting DHBs:

- Partner abuse was assessed 27% of the time (range 20%-100%)
- Child maltreatment was included in the medical diagnoses 44% of the time (range 0%-100%)
- Child protection concerns were included in the Discharge Summary 15% of the time (range 0%-100%)

These data indicate a need for improvement in service delivery and documentation of child protection concerns when a referral to Child, Youth and Family is initiated.

FINDINGS: SNAPSHOT

PARTNER ABUSE ASSESSMENT AND INTERVENTION

National estimates indicate that most women who received specialist family violence services during the three month audit period in 2015 were referred through the emergency department (n=982) or sexual health (n=446) VIP services. Both emergency and sexual health services had partner abuse disclosure rates greater than 5%; in addition, the emergency department has high patient volumes (Table 10).

- *Approximately one in every two women (48%) presenting to sexual health services are assessed for partner abuse.*
- *Approximately one in every two (48%) women admitted to postnatal maternity services are assessed for partner abuse (a significant increase from 33% in 2014.)*
- *For children admitted to child health inpatient services, approximately one of every three (35%) of their female caregivers are assessed for partner abuse.*
- *Approximately one in every four women (23%) presenting to emergency department services are assessed for partner abuse.*
- *The partner abuse disclosure rate among women in sexual health services (20%) is at least three times higher than the disclosure rate for women in postnatal maternity (4%), child health (4%) and emergency (6%) services.*

Table 10*: Population estimates of women who received partner abuse assessment and specialist partner abuse service (April - June 2014 and 2015)*

	Women screened		Disclosures		Referrals	
Service	**2014**	**2015**	**2014**	**2015**	**2014**	**2015**
Postnatal Maternity Inpatient						
Population estimate	2935	4,637	257	197	193	197
Weighted Mean	**33%**	**48%**	9%	4%	75%	100%
95% CI	26%, 39%	42%, 55%	3%, 14%	2%, 6%	*	*
Child Health Inpatient						
Population estimate	4869	4513	259	160	181	160
Weighted Mean	39%	35%	6%	4%	70%	100%
95% CI	31%, 48%	33%, 38%	4%, 9%	2%, 5%	*	*
Sexual Health						
Population estimate		2703		537		446
Weighted Mean		48%		20%		83%
95% CI		42%, 55%		13%, 27%		*
Emergency Department						
Population estimate		21,924		1310		982
Weighted Mean		23%		6%		75%
95% CI		20%, 26%		4%, 8%		*

Notes: Proportion of IPV disclosures is among those who were assessed for IPV; proportion of IPV referrals is among those who disclosed IPV; confidence intervals not calculated for referrals due to small numbers within individual DHBs. Sexual health and emergency department services not audited in 2014.

As stated earlier in this report, a partner abuse screening rate of 80% or greater is indicative of system reliability; and given the population prevalence, a disclosure rate of 5% or greater is expected as an indicator of screening quality. 2015 Snapshot average scores did not meet the benchmark (target zone, see Figure 14) for any of the four services.

Average scores, however, mask variability in service delivery. In 2015, there were seven service locations (included postnatal maternity or sexual health services within six DHBs) that achieved screening rates ≥ 80% and disclosures rates ≥ 5% (within the target zone). Service specific data is provided in the following sections.

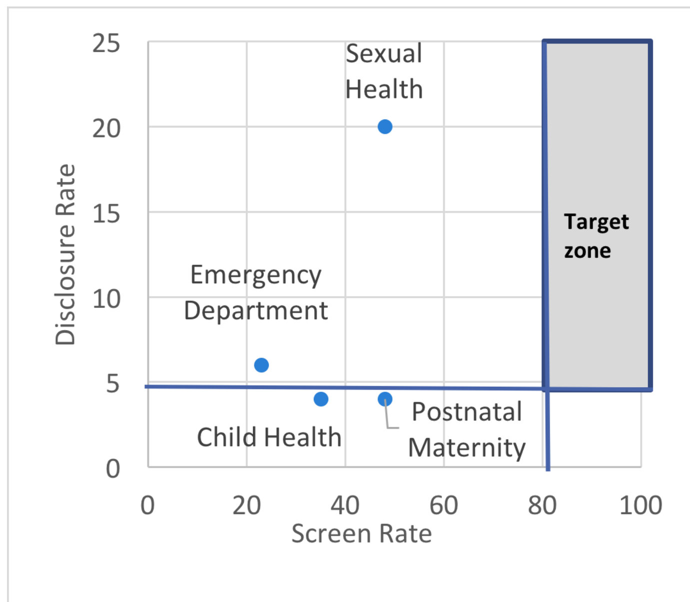


Figure 14. 2015 national average (weighted) partner abuse Snapshot screening and disclosure rates.

Postnatal Maternity

Across the 20 DHBs, 9,574 women were admitted to postnatal maternity services during the three month Snapshot audit period (1 April – 30 June 2015). Random sampling from the 22 locations (two DHBs reported on two locations) resulted in 576 cases audited for the 2015 Snapshot.

The IPV postnatal maternity snapshot screening rates ranged from 0% to 100% across DHBs (Figure 15). Four DHBs achieved the target screening rate of ≥ 80%: Northland, Bay of Plenty, Auckland, and Wairarapa. An additional three DHBs (Southern, MidCentral and West Coast) achieved screening rates between 75% and 80%. The DHB with 0% screening rate had not implemented VIP in the postnatal maternity service at the time of the audit.

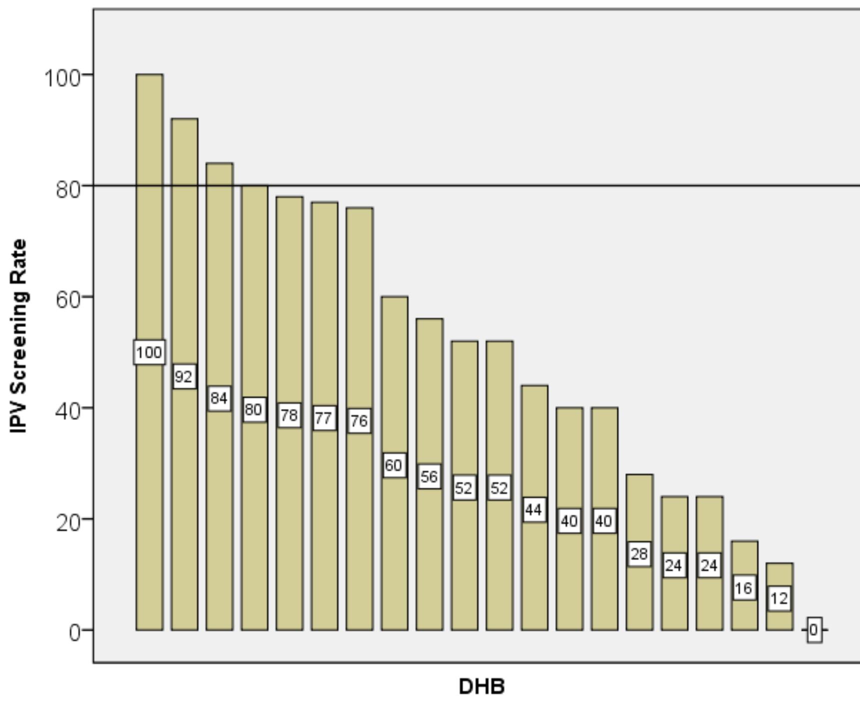


Figure 15. Distribution of Partner Abuse Screening Rates Across DHB Postnatal Maternity Services (N=20)

Among women who were screened, IPV disclosure rates ranged from 0% to 33% (Figure 16). Nine DHBs met the expectation that at least one of every twenty women screened would disclose abuse. The DHBs were: Lakes, Taranaki, Bay of Plenty, South Canterbury, Northland, Waitemata, MidCentral, Nelson Marlborough and Wairarapa.

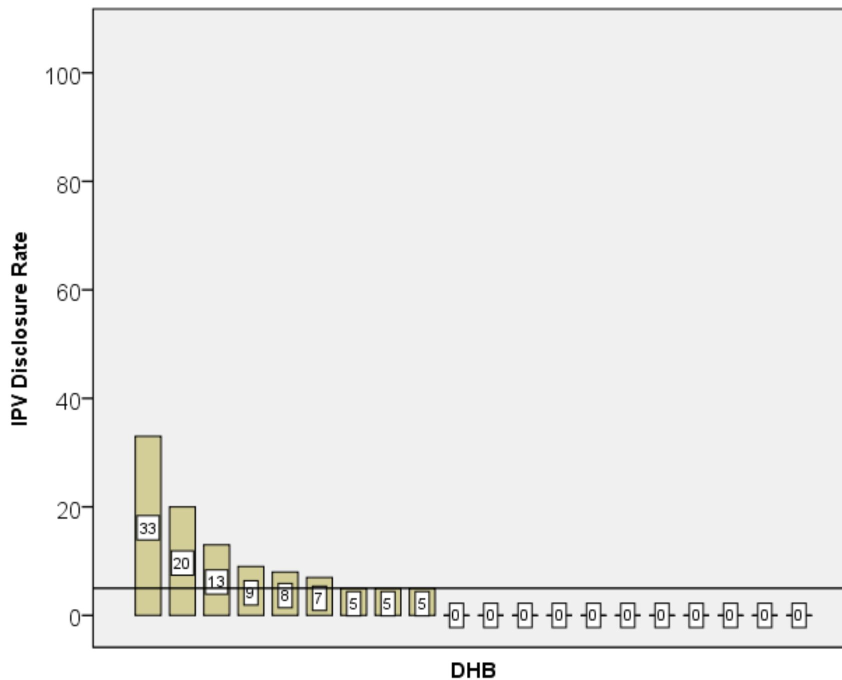


***Figure 16**.* Distribution of Partner Abuse Disclosure Rates Across DHB Postnatal Maternity Services (n=20)

In postnatal maternity services, three DHBs achieved the benchmark (≥ 80% screening with ≥ 5% disclosure rate; Figure 17): Bay of Plenty, Northland and Wairarapa.

Northland DHB has shared their experience in making service delivery improvements (Box 1). Their experience demonstrates what can be achieved.

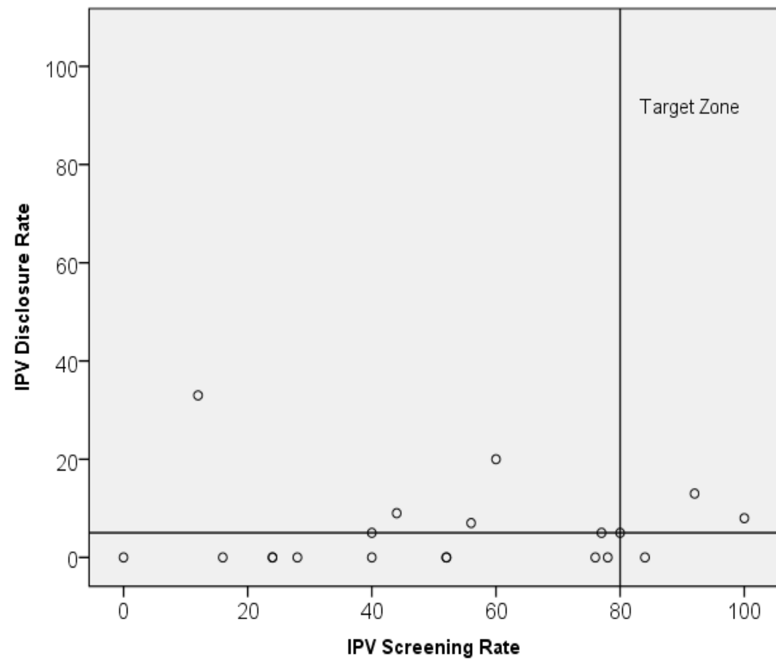


Figure 17. Plot of DHB partner abuse screening and disclosure rates for postnatal maternity services (N=20)

Box 1.

Improving Response to Partner Abuse results in Northland DHB Postnatal Maternity

Context:
All women 16 years and older, and teenage mums aged between 12 and 15, are routinely screened for family violence. In the 2014 Snapshot audit (April-June), Whangarei Hospital's Postnatal Maternity screening rate stood at 60% and disclosure rate at 0%, both below the national target. In 2015, Postnatal Maternity service delivery achieved the national target, with ≥ 80% screening and ≥ 5% disclosure rates across three quarterly audits.

Progress:
The PDSA cycle framework enabled FVICs to plan, monitor and evaluate the effectiveness of interventions.

- Actions included: weekly visits to key areas, 'level of comfort' surveys, regular in-service sessions for staff, quarterly audit of screening and disclosure rates;
- Results monitored and disseminated to Clinical Nurse Manager to share with staff;
- Sound working relationship between Clinical Nurse Manager, Social Worker and FVIC have enabled a collaborative process to identify the VIP champion and develop the role.

Challenges:

- Sustaining core and refresher training attendance to maintain competence in screening and management of disclosures.
- Maintenance and future proofing the champion role within the clinical area to ensure that annual leave or resignation will have minimal impact on the VIP programme.
- Development of pathways to enable screening of transient and short stay women on the postnatal maternity ward.
- Engaging Lead Maternity Carers (LMCs) who work within the environment but who are not employed by DHB.
- Provision of a private and safe screening environment away from woman's partners and visitors.

Lessons Learnt

- Collaboration ensured commitment to the VIP process and consistency in its delivery.
- Sustainability, visibility and consistency are paramount to success.
- Working within the PDSA framework guides informed improvement opportunities.
- Implementation of the VIP champion role within the clinical area ensures ongoing support amongst clinical colleagues.
- Enabling the VIP champion to implement and drive area appropriate initiatives to encourage and streamline screening (e.g. a visual cue in the nurses' station showing women screened/not screened) helps to ensure and maintain robust processes.
- Consistent VIP coordinator visits to the clinical area are highly valued and ensure visibility.
- Staff VIP training supports increased level of comfort among colleagues and sustainability of screening.
- Perseverance is necessary to achieve screening rates. At times it is difficult to speak to a woman alone on the ward and so screeners may have to try several times before succeeding in screening their patients.
- Celebrate successes with all involved.

Based on the Snapshot weighted mean for IPV screening (48%; 95% CI 42%, 55%), we estimate that 4,637 women admitted to postnatal maternity services during the three month audit period (April-June 2015) received a VIP intimate partner abuse screen (See Table 11).

Based on the Snapshot weighted mean for IPV disclosure (4%, 95% CI 2%, 6%), we estimate that 197 women disclosed intimate partner violence to a health care provider, with 197 (100%) women receiving a referral for special services. Importantly, we estimate that 99 women received an active specialist consultation during her health care admission.

Table 11. Postnatal maternity services inpatient population estimates of women who received intimate partner violence (IPV) screening intervention (April-June 2015)

Partner Abuse Screening, Disclosure and Referral Rates	Number	95% CI
Eligible women admitted to service	**9,558**	
Estimated number of women who were screened for IPV	**4,637**	**4 033, 5 241**
Estimated number of women who disclosed IPV	**197**	**114, 280**
Estimated number of women who received referrals: To active (onsite) specialist services: 99 To passive (offsite) specialist services: 98	**197**	

Table notes: CI=Confidence Intervals; CIs not computed for referrals as cell sizes small.

Child Health Inpatient

Nationally, 20 DHBs provided data from 22 child health inpatient locations. They reported that a total of 12,746 children were admitted during the three month audit period (1 April – 30 June 2015). Random sampling from the 22 locations resulted in 550 cases audited for the 2015 Snapshot.

The IPV child health inpatient snapshot screening rate of female parents, guardians or caregivers, ranged from 12% to 92% (Figure 18). West Coast DHB achieved the target screening rate of greater than 80%. The one DHB who had not fully implemented VIP in child health inpatient services achieved a screening rate of 12%.

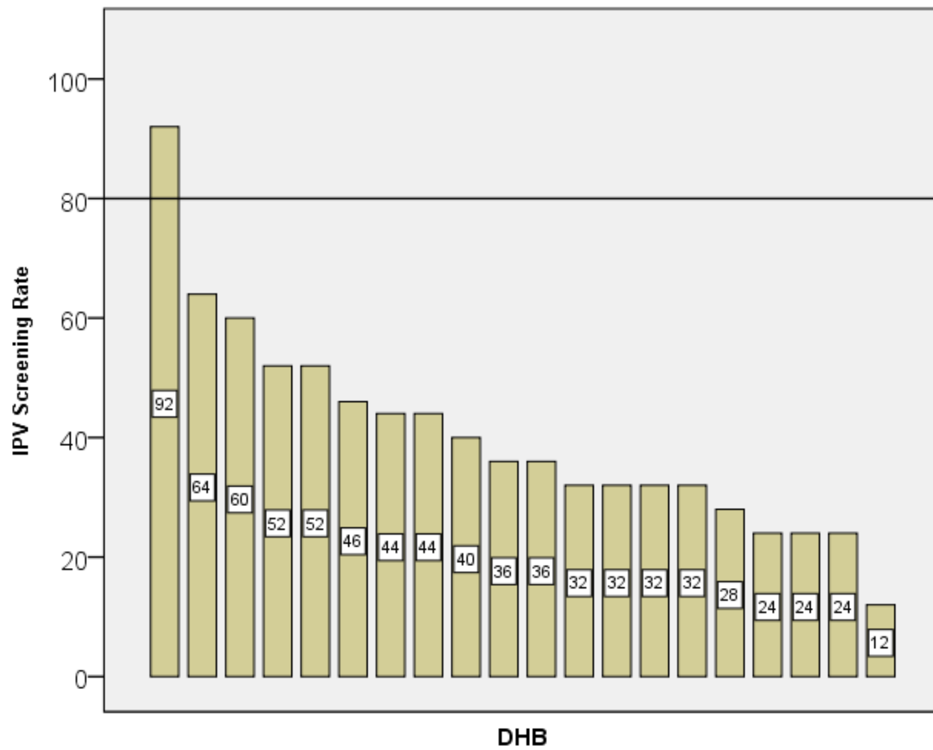


Figure 18. Distribution of IPV Screening Rates Across DHB Child Health (n=20)

Among women who were screened, disclosure rates ranged from 6% to 33% across the 7 DHBs with a non-zero screening rate (Figure 19). Seven DHBs met the expectation that at least one of every twenty women screened would disclose abuse. The DHBs were: Auckland, Wairarapa, Whanganui, Hutt Valley, Tairawhiti, Taranaki and Bay of Plenty.

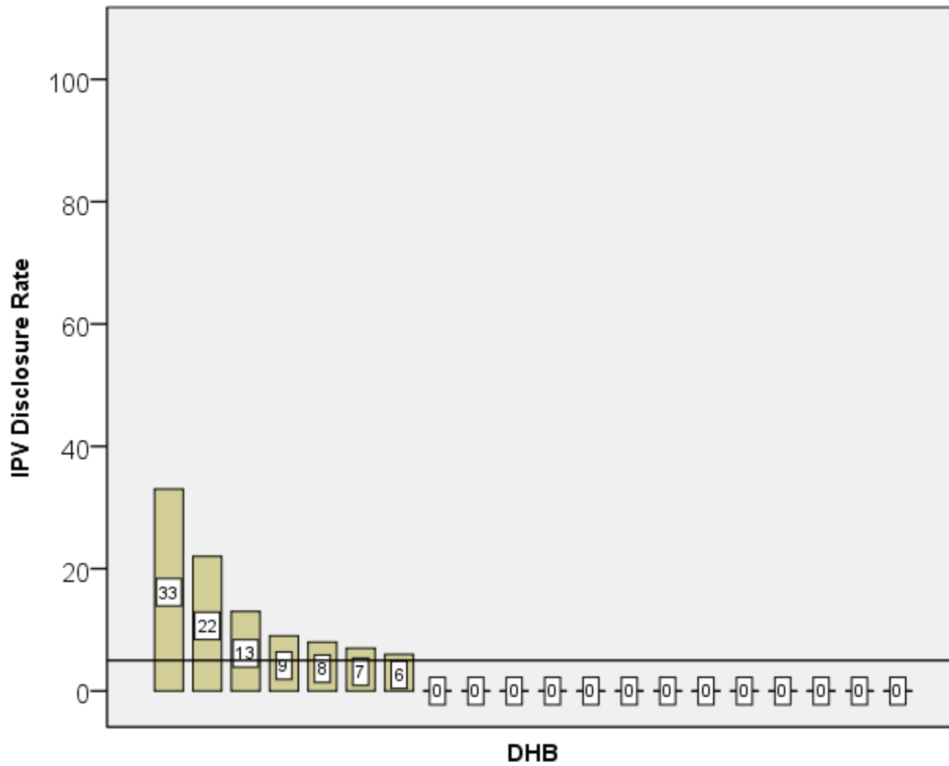


Figure 19. Distribution of IPV Disclosure Rates Across DHB Child Health (n=20).

In child health services, no DHBs achieved the benchmark (≥ 80% screening with ≥ 5% disclosure rate; Figure 20). That said, two DHBs (Bay of Plenty and Taranaki) achieved a 60% or greater screening rate with a disclosure rate ≥ 5%.

Based on the Snapshot weighted mean for IPV screening (35%; 95% CI 33%, 38%), we estimate that 4,513 female caregivers of children admitted to general paediatric wards during the second quarter of 2015 received a VIP intimate partner violence screen (see Table 12).

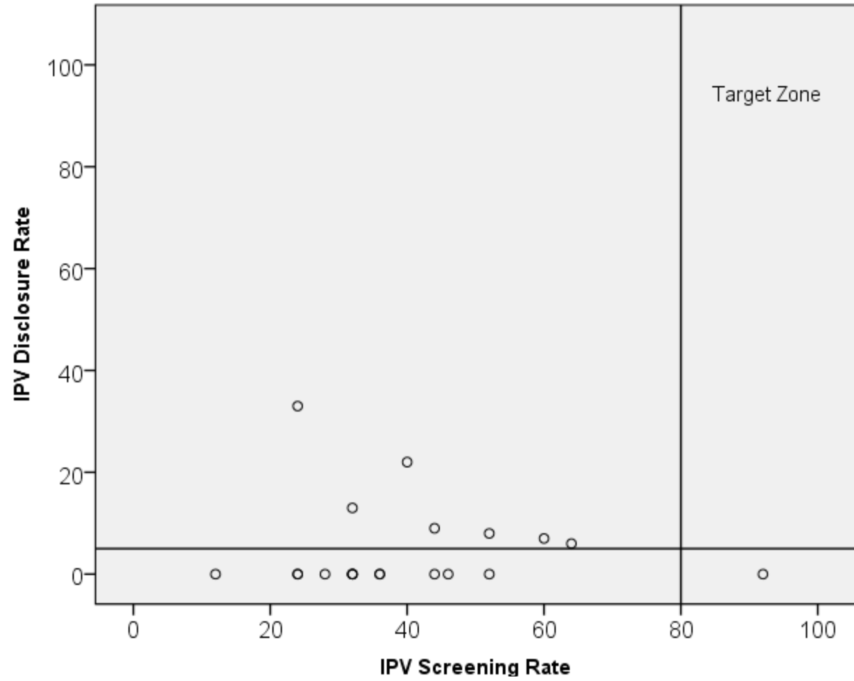


Figure 20. Plot of DHB IPV Screening and Disclosure rates for Child Health Inpatient Services.

Based on the Snapshot data weighted mean for IPV disclosure (4%; 95% CI 2%, 5%), we also estimate that 160 women disclosed IPV to a health care provider, with 160 women (100% of those who disclosed abuse) receiving a referral for specialist services. Importantly, we estimate that 107 women received an onsite (active) specialist consultation during her admission.

Table 12. Child health inpatient population estimates of women who received intimate partner abuse (IPV) screening and service (April-June 2015)

Partner Abuse Screening, Disclosure and Referral Rates	Number	95% CI
Children admitted to service	**12,746**	
Estimated number of female caregivers screened for IPV	**4,513**	**4180, 4847**
Estimated number of female caregivers who disclosed IPV	**160**	**83, 237**
Estimated number of women who received referrals: To active (onsite) specialist services: 107 To passive (off site) specialist services: 53	**160**	
Notes: CI=Confidence Intervals; CIs not computed for referrals as cell sizes small.		

Emergency Department [adult]

Nationally, 20 DHBs provided data from 22 emergency departments. They reported that 95,668 women presented to the emergency departments during the three month audit period (1 April – 30 June 2015). Random sampling from the 22 locations resulted in 551 cases audited for the 2015 Snapshot.

The IPV emergency department snapshot screening rate of women aged 16 years and over ranged from 0% to 68% (Figure 21). One of the four DHBs with a 0% screening rate had not implemented VIP in their service.

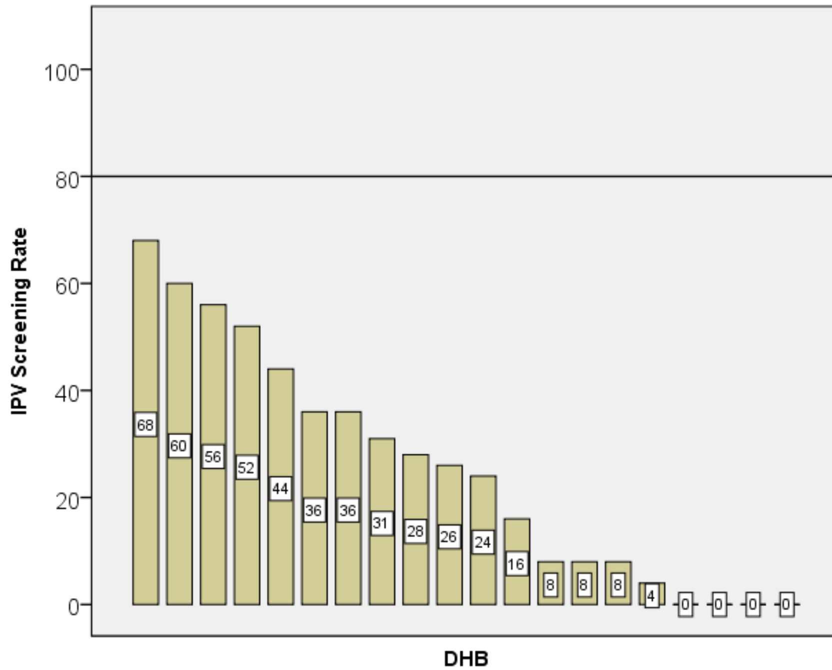


Figure 21. Distribution of IPV screening rates across DHB emergency departments (n=20)

Among women who were screened, in the 16 DHBs with a nonzero screening rate, IPV disclosure rates ranged from 0% to 100% (Figure 22). Six DHBs (MidCentral, Tairawhiti, Taranaki, Waitemata, South Canterbury and Bay of Plenty) met the expectation that at least one in every twenty women screened would disclose abuse.

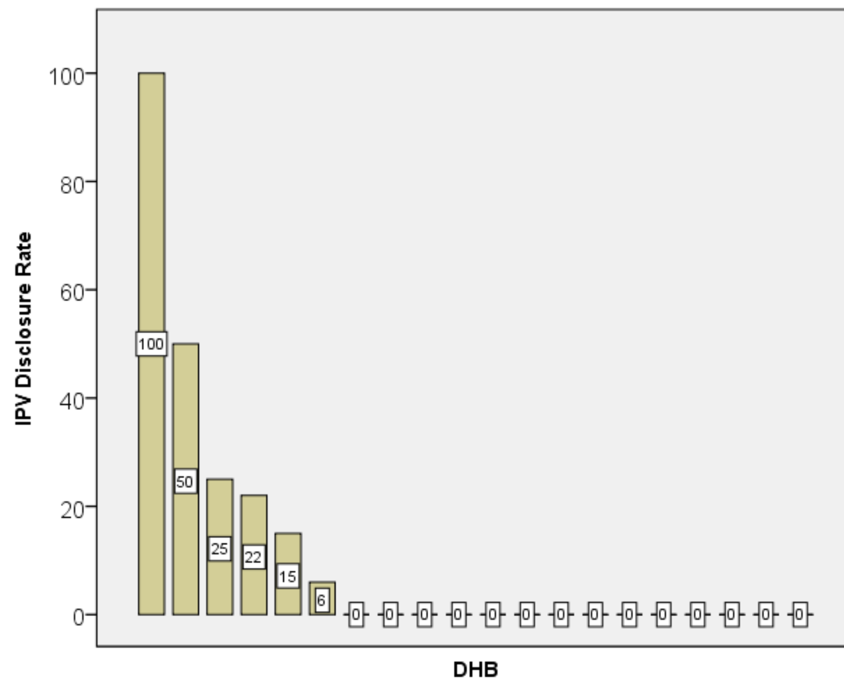


Figure 22. Distribution of IPV disclosure rates across DHB emergency department s (n=20)

In emergency department services, no DHBs achieved the benchmark (≥ 80% screening with ≥ 5% disclosure rate; Figure 23). Two DHBS achieved a screening rate between 50% and 80% with disclosure rates ≥ 5% (MidCentral and Taranaki).

Two DHBs reported high disclosure rates with minimal partner abuse screening, consistent with disclosure-related identification (level 1 identification[1]) rather than routine screening.

Based on the Snapshot weighted mean for IPV screening (23%; 95% CI 20%, 26%) we estimate that 21,924 women who presented to the adult emergency department during the second quarter of 2015 received a VIP intimate partner violence screen (see Table 13).

Based on the Snapshot data weighted mean for IPV disclosure (6%; 95% CI 4%, 8%) we estimate that 1,310 women disclosed intimate partner violence to a health care provider, with 983 women receiving a referral for specialist services. We estimate that 492 women received an active (onsite) specialist consultation during their admission.

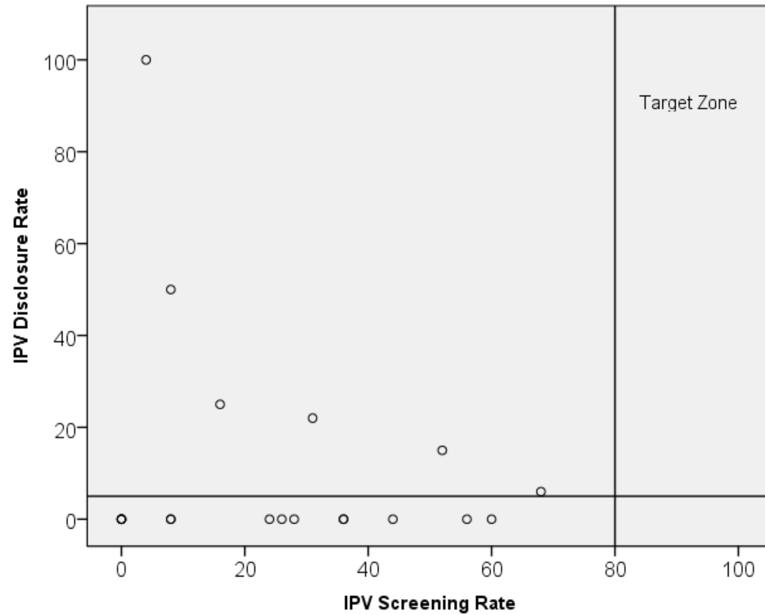


Figure 23. Plot of DHB IPV Screening and Disclosure Rates for adult DHB emergency department

Table 13. Emergency department population estimates of women who received Intimate Partner Violence (IPV) screening and service (April-June 2015)

Partner Abuse Screening, Disclosure and Referral Rates	Number	95% CI
Eligible Women presenting to service	**95,668**	
Estimated number of eligible women screened for IPV	**21,924**	**18 819, 25 029**
Estimated number of eligible women who disclosed IPV	**1310**	**917, 1702**
Estimated number of women who received referrals: To active (onsite) specialist services: 492 To passive (off site) specialist services: 491	**983**	
Table notes: CI=Confidence Intervals; CIs not computed for referrals as cell sizes small.		

Sexual Health Services

Nationally, 14 of the 15 DHBs providing sexual health services submitted Snapshot data in 2015. They reported that 5,590 women presented to the sexual health service during the three month audit period (1 April – 30 June 2015). Random sampling from the 14 locations resulted in 403 cases audited for the 2015 Snapshot. One DHB did not submit any data for 2015 audit period due to implementation of new IT systems that did not facilitate the audit process.

The IPV sexual health service Snapshot screening rate for women aged 16 years and over ranged from 0% to 93% (Figure 24). Five DHBs (Nelson Marlborough, Tairawhiti, Waikato, Bay of Plenty, and Southern) achieved the target screening rate of greater than 80%. The DHB with a 0% screening rate had not yet implemented VIP into the service.

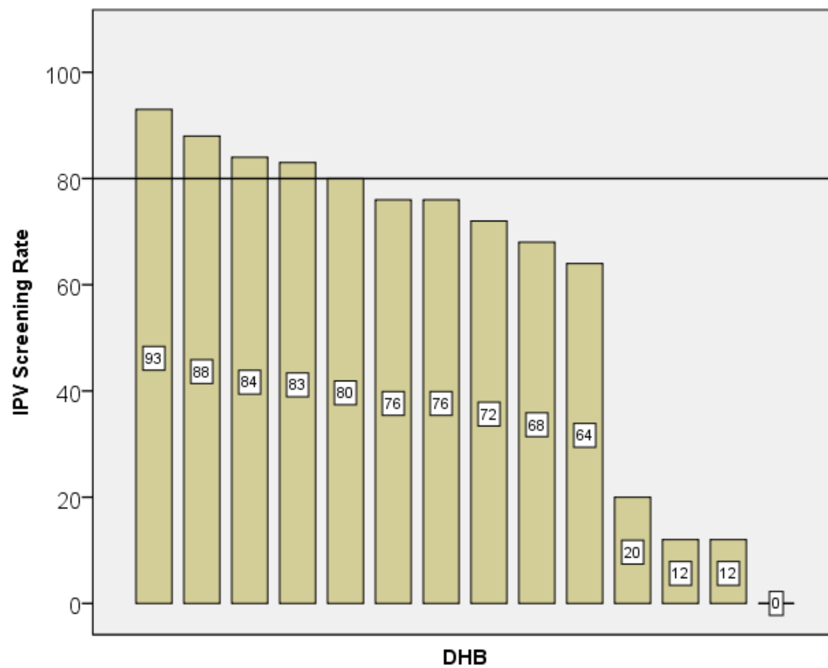


Figure 24. Distribution of IPV screening rates across DHB sexual health services (n=14)

IPV disclosure rates ranged from 0% to 100% (Figure 25). Nine DHBs met the expectation that at least one in every twenty women screened would disclose abuse (Auckland, Hawkes Bay, MidCentral, Taranaki, West Coast, Nelson Marlborough, Southern, Waikato and Bay of Plenty).

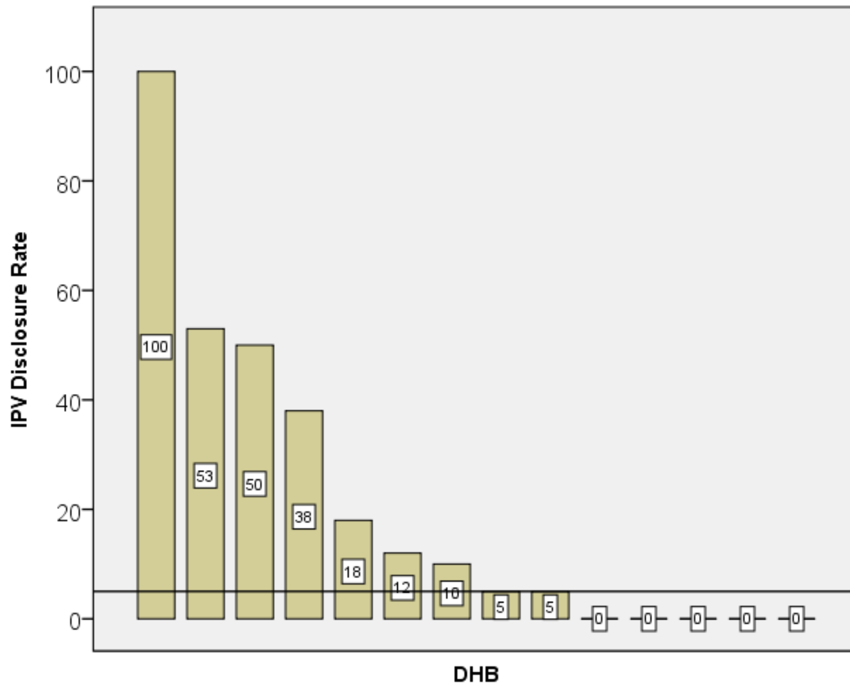


Figure 25. Distribution of IPV disclosure rates across DHB sexual health services (n= 14)

In sexual health services, four DHBs (Nelson Marlborough, Bay of Plenty, Southern and Waikato) achieved the VIP Snapshot benchmark (≥ 80% screening with ≥ 5% disclosure rate; Figure 26).

Sexual health services have a long standing practice of assessing for both historical and current partner and sexual violence. Waikato DHB describes adapting their sexual health service abuse assessment routine to the Violence Intervention Programme in Box 2.

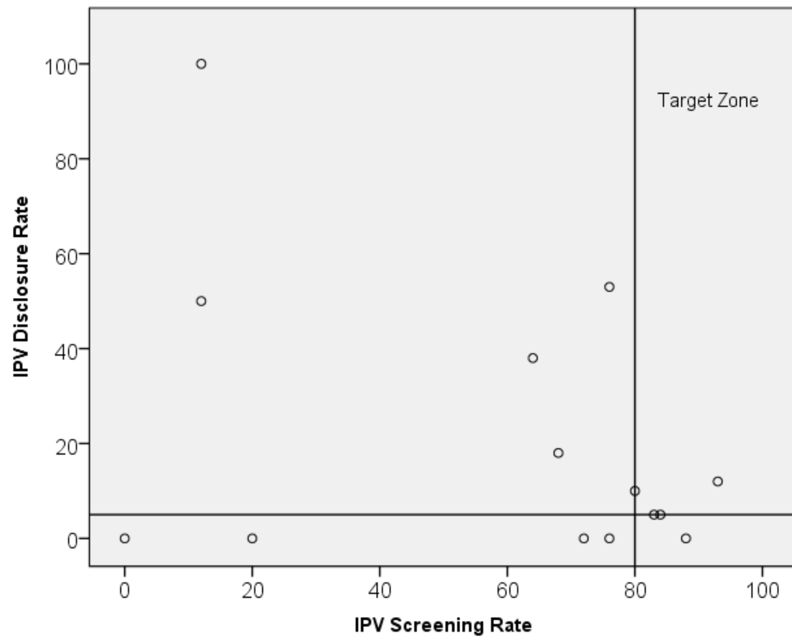


Figure 26. Plot of DHB IPV Screening and Disclosure Rates for Sexual Health Services

Based on the Snapshot weighted mean for IPV screening (48%; 95% CI 42%, 55%), we estimate that 2,703 women presenting to the sexual health services during the second quarter of 2015 received a VIP partner abuse screen (see Table 14).

Based on the Snapshot data weighted mean for IPV disclosure (20%: 95% CI 13%, 27%), we estimate that 537 women disclosed partner abuse to a health care provider, with 448 women receiving a referral for specialist services. We estimate that 75 women received an active specialist

consultation.

Table 14. Sexual health services population estimates of women who received intimate partner violence screening and service (April-June 2015)

Partner Abuse Screening, Disclosure and Referral Rates	Number	95% CI
Eligible Women admitted to service	**5,590**	
Estimated number of women who were screened for PA	**2,703**	**2330, 3076**
Estimated number of women who disclosed PA	**537**	**349, 725**
Estimated number of women who received referrals: To active (onsite) specialist services: 90 To passive (off site) specialist services: 358	**448**	

Notes: CI=Confidence Intervals; CIs not computed for referrals as cell sizes small.

Box 2

Improved results in Waikato DHB sexual health service (2015)

Context

Sexual health services (SHS) at Waikato DHB have always prioritised questioning around abuse, particularly sexual abuse (historical and current). Relevant questions have been included on the Sexual History Sheet used for assessment within the service. These standard questions focus on whether sexual abuse or domestic violence has occurred and whether counselling is currently being (or has been) accessed.

Progress:

Over the past 12 months progress has been made in transitioning from the questions around sexual abuse/domestic violence already embedded in SHS practice to incorporating questions asked routinely as part of the national family violence screening process.

Challenges:

- Gaining support from staff for new screening format, particularly from those who are experienced around questioning around sexual abuse (historical and current).
- Introducing the screening format while maintaining and preserving the gathering of historical information important to the nature of the Sexual Health Service assessment process.
- Incorporating new screening information into existing documentation whilst still providing a clear documentation process.
- Creating a clear understanding between the distinction between historical and current disclosures of abuse and pursuing the appropriate pathways.
- Creating a system for submitting regular monthly audit data for the DHB intranet alongside other reporting services.

Lessons Learnt:

The importance of:

- Valuing ideas and input from staff in regard to processes of change, whilst supporting the reasons behind the change.
- Establishing adequate support and referral pathways (e.g. social work, community agencies) to assist those who have made a current or historical disclosure of abuse.

"If you want to go fast, go alone.
If you want to go far, go together".
African proverb.

CHILD ABUSE & NEGLECT ASSESSMENT & INTERVENTION

National estimates indicate that 374 (95% CI 251, 497) children presenting for emergency services were assessed to have a child protection concern during the three month audit period in 2015 (Table 15). In all cases, specialist consultation occurred.

- *Clinical assessment of children under two years of age presenting to an emergency department includes a child protection screen for approximately one of every four (26%).*
- *Specialist child abuse and neglect consultation occurs consistently (100%) when a child protection concern is identified.*

Table 15. Emergency department population estimates of children under two years of age who received child abuse and neglect (CAN) assessment and service (April - June 2014 and 2015)

	Children assessed for CAN indicators		CP Concern (≥1 positive indicator)		Specialist Consultation	
	2014	**2015**	**2014**	**2015**	**2014**	**2015**
Population estimate	4163	4242	549	374	489	374
Weighted mean	27%	26%	13%	9%	89%	100%
95% CI	20%, 34%	21%, 32%	8%, 18%	6%, 12%	*	*

Notes: proportion of child protection (CP) concern is among those who received a CAN assessment; proportion of specialist consultation is among those with an identified CP concern; confidence intervals not calculated for specialist consultation due to small numbers within individual DHBs.

Emergency Department

Nationally, 20 DHBs (100%) provided data from 22 emergency department locations. They reported that a total of 16,135 children under two years presented for any reason to the emergency department during the three month audit period (1 April – 30 June 2015). Random sampling from the 22 locations resulted in 575 cases audited for the 2015 CAN Snapshot.

The CAN snapshot child protection assessment rate, for children under two presenting to emergency services for any reason, ranged from 0% to 76% across the DHBs (Figure 27).

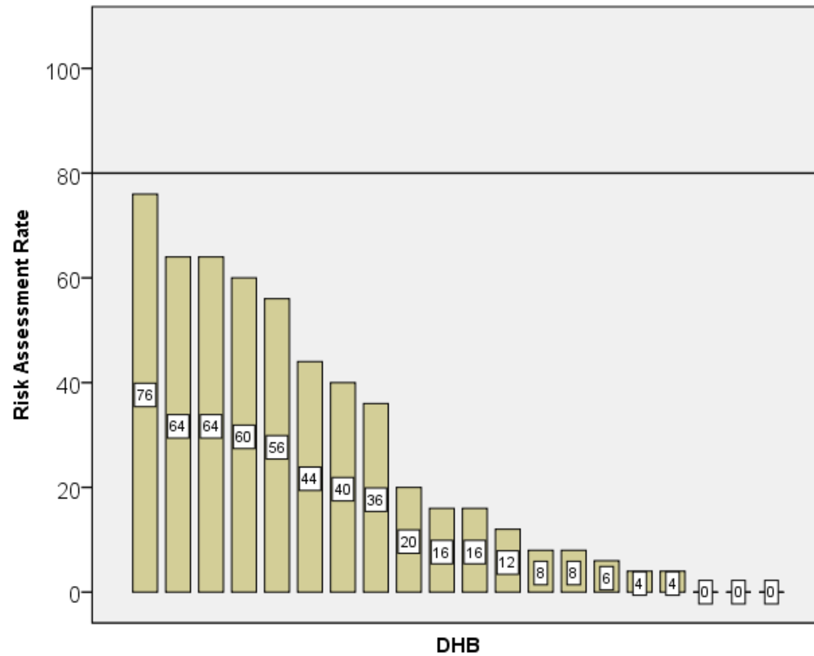


Figure 27. Distribution of child abuse & neglect assessment rate across DHB emergency departments

Among the 17 DHBs that had a child abuse and neglect assessment rate greater than zero, six identified a CAN concern (one or more positive indicators) in one or more children (Figure 28).

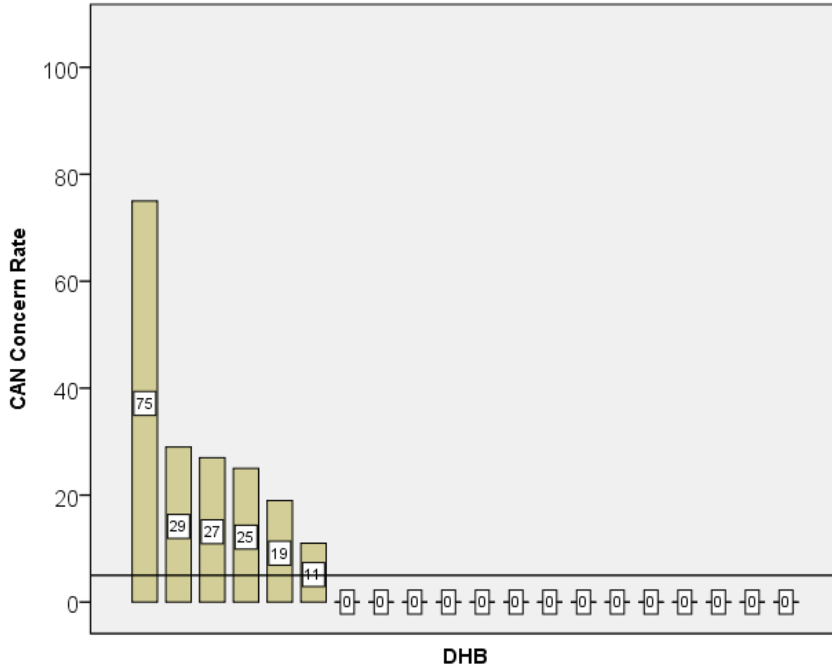


Figure 28. Distribution of CAN Concern Rates across DHB Children's / Emergency Departments

One DHB (MidCentral) achieved a CAN assessment rate between 75% and 80% with a CAN concern rate of 5% or above (Figure 29).

Based on the Snapshot weighted mean for CAN assessment (26%; 95% CI 21%, 32%), we estimate that 4,424 children under two years of age seen in an acute hospital emergency department were assessed for abuse during the three month audit period (see Table 16).

Based on the Snapshot data weighted mean for CAN identification of risk factors (9%; 95% CI 6%, 12%), we estimate that 374 children had a CAN concern identified. All 374 children (100%) with a CAN concern identified were reviewed for child abuse and neglect by a specialist.

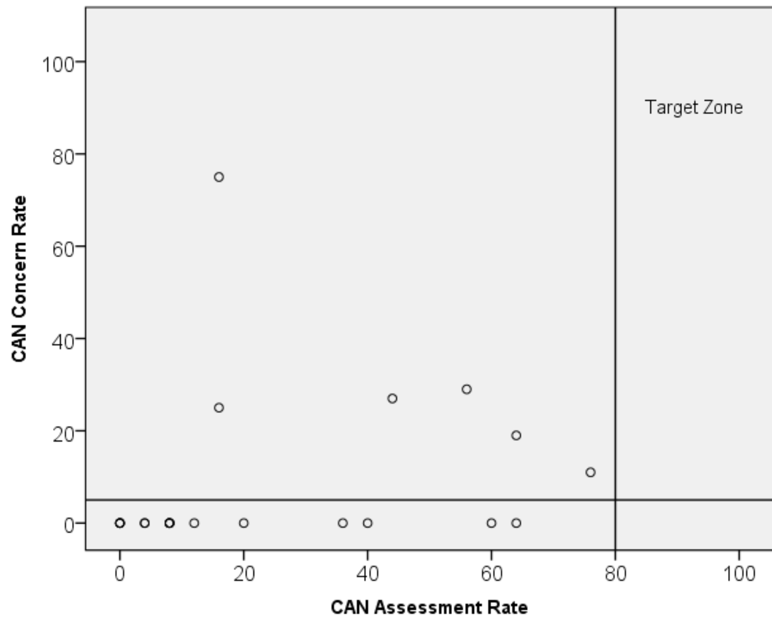


Figure 29. Plot of DHB Child Abuse and Neglect Assessment and Concern Rates for Children under two years of age presenting to the Emergency Department.

Table 16. Emergency Department population estimates of children under two years of age who received CAN assessment and service (April-June 2015)

Reported Assessment, Identification of Concern and Specialist Consultation	Number	95% CI
Children presenting to ED under 2 years for any reason	**16,135**	
Estimated number of children assessed for CAN indicators	**4242**	**3 387, 5 096**
Estimated number of children with one or more positive CAN indicators	**374**	**251, 497**
Estimated number of children whose cases were reviewed for CAN with specialist	**374**	

Note: CI=Confidence Intervals; Cis not computed for consultations as cell sizes small with many ‘0’ cells.

ETHNICITY

2014 and 2015 assessment rates for child abuse and neglect indicators among children under 2 years presenting to an emergency department were examined for Māori and non-Māori (Table 17). The relative under-assessment for child abuse and neglect indicators of non-Māori children compared to Māori children resolved in 2015. All groups, however, are not consistently assessed (rate below target of 80%).

Table 17. CAN Assessments by Ethnicity in the Emergency Department

CAN Assessment	2014		2015	
	Non Māori	**Māori**	**Non Māori**	**Māori**
CAN Assessment/Reviewed	72/391 18%	50/175 29%	107/392 27%	45/183 25%
(95% confidence interval)			(23%, 32%)	(18%, 31%)
Note: These are crude rates over all DHB reported data and not adjusted for the ethnic variation across DHBs.				

2014 and 2015 assessment rates for partner abuse were examined for Māori and non-Māori (Table 18). The difference in assessment rates between Māori and non-Māori in 2015 was the largest in sexual health services (absolute difference of 10%; non-Māori under-assessed), followed by postnatal maternity (absolute difference 7%; Māori under-assessed). This raises the question as to why Māori and non-Māori are being treated differently, though both are underserved (less than 80% assessment rates). We will continue to examine the pattern of VIP implementation across ethnicity in future Snapshot audits.

Table 18. IPV Assessments by Ethnicity

IPV Screening	2014		2015	
	Non Māori	**Māori**	**Non Māori**	**Māori**
Postnatal Maternity	160/429 37%	53/120 44%	229/439 52% (47%, 57%)	60/137 44% (35%, 52%)
Child Health Inpatient	266/429 37%	110/336 33%	142/374 38% (33%, 43%)	73/169 43% (36%, 51%)
Emergency Department	NA	NA	118/447 26% (22%, 31%)	26/104 25% (17%, 33%)
Sexual Health	NA	NA	164/277 59% (53%, 65%)	69/101 68% (59%, 78%)
Notes: These are crude rates over all DHB reported data and not adjusted for the ethnic variation across DHBs; Child health inpatient in 2015 excludes 7 cases where there was documentation of no female caregiver; 2015 (,) = 95% confidence interval				

FINDINGS: QUALITY IMPROVEMENT and PDSA CYCLES

In 2015, DHBs were asked to firstly submit their PDSA Plan to the evaluation team by November 2015. Thirty nine PDSA cycle plans were submitted by eighteen DHBs (2 DHBs did not submit any PDSA plans). All DHBs had the opportunity to revise their PDSAs based on evaluator feedback. Secondly, DHBs were asked to submit their completed PDSAs to evaluators in April 2016. Twenty-two completed PDSAs were submitted.

2014 Snapshot results provided baseline data to focus 2015 programme improvement change efforts. Eight PDSAs involved achieving clinical compliance with the use of ED child injury flow charts; fifteen PDSAs focused on improving IPV screening rates in those services that were or would be subject to VIP snapshot clinical audits in 2015 or 2016. Two PDSAs were abandoned due to an inability to increase rates beyond the base measure. Others achieved improvements initially but then dropped off.

Changes implemented included the elimination of quality problems, improving quality without additional resources, expanding staff and management expectations to focus on core processes and purpose, and to change the clinical work environment by introducing training, access to information, and facilitating clarity about expectations.

In conducting PDSAs, several issues emerged. These included:

- Identifying aims and objectives involved building relationships and engagement with service management and clinical staff before the actual PDSA could be implemented.
- Relationship building, collaboration and planning always took longer than expected in the busy DHB environment and support was not necessarily always forthcoming in the timeframes expected.
- Submitted cycle timeframes were substantially longer (e.g., 6 months) than would normally be associated with PDSAs (e.g. two weeks).
- Submitted plans were often too complex.

Several DHBs successfully applied the PDSA cycle to enhance performance and to improve the consistency and quality of their family violence service delivery response. Several of these DHBs were invited to share what has contributed to their achievement. Northland and Waikato DHB journeys were outlined above under Postnatal Maternity (Box 1) and Sexual Health (Box 2) services. Bay of Plenty's contribution follows (Box 3). An example of a PDSA improvement cycle from Lakes DHB is provided in Box 4.

Box 3. Bay of Plenty DHB's VIP Programme (2015)

Context:

- VIP implemented in all targeted services.
- The VIP strategic plan and the VIP governance group are key elements of the successful VIP Programme within the DHB.
- VIP training is well delivered and well received.
- **PDSAs** were used in Sexual Health for the Introduction and adoption of a new computer system that included the family violence screening questions.
- Bay of Plenty VIP IPV screening results are in the target zone for Postnatal Maternity and Sexual Health.

Progress:

- Regular audits are undertaken and the good and not so good results go back to the manager and team first.
- Have established a Family Violence screening month in the Emergency Department with a major push to undertake more screening.
- The importance of family violence in mental health cannot be understated. If the services are working holistically with mentally unwell people, they need to know whether there are children in the family. "How can you help them if you don't know about their stressors?" VIP Team is working with Mental Health to see how VIP can fit into their core business. VIP takes the angle that they are already doing some of it.
- Internal social workers are part of the VIP team. It's the services first port of call, it's their role. FVICs work with Maternity social workers to develop or assist with plans for new-born babies.
- Mantra – "it's really important to screen for family violence. Yes, other things are compulsory, but reduction of family violence is so important."
- Maternity patients have a special relationship with staff; they are there for a longer time, are vulnerable and trust the staff. Screening underway in all areas– SCUBU, wards, post and antenatal maternity.

Challenges:

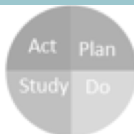
- Achieving consistency across two sites, urban and rural.
- Time pressures
- Finding true champions who are committed to VIP (and not just going through the motions)
- Ethical balance between a woman and a child

Lessons Learnt:

- Go slow. Don't rush. Gently and slowly. Don't force. Don't power over! Go with!
- Relationships are very valuable
- Get staff to understand the importance of screening. All staff want to make a difference to patients' lives and VIP is just another service (like heart operations) that makes a huge difference to women and children's lives.
- Undertake regular walk arounds "how are you going?"
- Give regular acknowledgement to staff, services and managers – highlight what they are doing well and build on what they are doing right (and not what they are doing wrong). Keep the momentum going and support staff.
- FVIC tells people that she totally believes in the VIP programme. She emphasises that the positive impact of screening and intervention may not be evident at an initial assessment. A woman may return 6 months later saying she wants help. Next time it might be the right time.

Box 4. Lakes DHB PDSA Example

MODEL FOR IMPROVEMENT – PDSA CYCLE



Lakes DHB

Cycle: 1	**Planned Start Date:** 18-01-2016	**Planned Finish Date:** 31-01-16	**Actual Finish Date:**

Objective for this PDSA Cycle: To determine whether incorporating the ED Child Injury triage tool into the ED documentation front sheet increases clinical compliance.

Plan: Briefly describe the change we plan to test.

The ED Child Injury triage tool will be incorporated in the ED documentation front sheet (rather than using a stand-alone form as has been the case historically). Following this, we will audit compliance with the use of the tool for the target group (children <6yrs presenting with injury).

Questions: What question (s) do we want to answer on this PDSA Cycle?
Will incorporating the ED Child Injury triage tool in the ED documentation increase compliance?

Prediction: What do we think will happen?
Compliance will increase.

Data: What data will we need to test our predictions (s)? How will we collect it?
ED documentation front sheets for the audit group

Tasks to be completed for Test	Who	When	Where and How
Pre-change audit (2015 snap-shot audit outcomes: 0% compliance)			Already completed
Post-change audit	SHO	Jan 2016	Manual review of Child Injury triage tool on ED documentation for audit group

Do: Carry out the change or test. Collect Data and begin analysis.

What problems or unexpected events did we encounter?
On four occasions a line had been drawn through the tool, reason for this/outcome unclear.
Feedback and observations from participants?
The change provided a positive prompt for clinical staff.

Study: Complete analysis of data.

What does the data show?
The tool was used for 73% (47/64) of children<6yrs presenting with injury; for 65% (11/17) of children<2yrs.
Was your predication confirmed? If not what did you learn?
Yes – a significant increase in compliance from the 0% baseline.
Compare the data to your predictions and summarise the learning.
There was a significant increase in compliance in use of the ED Child Injury triage tool as a result of it being included in the ED documentation front sheet, although the next stage of the injury assessment process had not always been initiated where it was indicated. Further training is required.

Act:

Following this test we will (tick one): ☒Adopt ☐Adapt ☐Abandon this change

What is our plan for the next cycle?
Re-audit using more specific audit criteria to identify any further systems changes required as well as training needs. The audit will include all children <6years presenting to ED.

DISCUSSION

The Violence Intervention Programme evaluation in 2015 aimed to (a) measure service delivery consistency and quality in Ministry of Health targeted services and (b) foster system improvements. The health response to family violence is directed by national assessment and intervention guidelines[1,2,44] and supported by a health systems approach.

Abuse assessment rates provide a measure of service consistency. Among 95 locations providing 2015 clinical Snapshot data across the 20 DHBs and 5 services,[a] 10% (n=10) achieved an IPV assessment rate of 80% or higher. This was an improvement from the inaugural Snapshot audit in 2014, where 3% of locations (2/60 locations involving 20 DHBs and 3 services) met the assessment target. No DHB met this target for child abuse and neglect assessment for children under two years of age presenting to an emergency service. The 2015 evaluation data indicates that the assessment of family violence within health services is currently inconsistent.

Significant variation exists in family violence assessment rates by service, from 23% for women presenting to emergency departments, to 48% for women in postnatal maternity and women caregivers for children admitted to the hospital. Of the three services involved in the 2014 VIP Snapshot clinical audits, postnatal maternity services increased their mean screening rate (from 33% in 2014 to 48% in 2015). Variation across services was also evident in the New South Wales 2014 domestic violence Snapshot, ranging from 46% in mental health to 93% in women's health.[45,b]

Abuse identification rates provide a measure of service quality as well as the underlying prevalence rate among service users. Among 95 locations providing clinical Snapshot data, for women who were assessed for IPV in the past 12 months and children under two years of age assessed for child abuse and neglect, 34% (n=37) achieved the target identification/disclosure rate of 5% or higher. The identification of IPV was highest in sexual health services (20%), compared to in emergency (6%), child health (4%) and postnatal maternity (4%) services. The 6% identification of IPV among women presenting to the emergency department is significantly lower than the 18%[22] and 21%[19] 12 month prevalence identified in two New Zealand studies. The identification rate of a child protection concern in children under two years of age presenting to an emergency department was 9%.

There are several DHBs who have not implemented VIP in all targeted services and others who have implemented VIP, but achieved zero or very low rates of family violence assessment, identification and intervention. There are a variety of explanations that have been offered, such as insufficient nursing and/or social work staff to provide an appropriate intervention for those who disclose abuse or in whom there is a concern, lack of senior management support and practical physical structural issues (e.g. curtained cubicles are not sufficient for confidential conversations). Such barriers are limitations that the health system can overcome if there is the will to do so. Lack of achievement is not acceptable given the high prevalence of family violence in New Zealand[17,46] and the significant impact of family violence on health and well-being.[24,47] It is recommended that a health response to family violence be made a New Zealand health target. A health target would signal that the assessment for family violence and accompanying interventions are mandatory. This would be supported by designating family violence core training as a Key Performance Indicator.

Overtime, DHBs have achieved significant infrastructure to support a systems approach for responding to intimate partner violence and child abuse and neglect. Ongoing improvements are

[a] Sexual health services provided by 15 DHBs

[b] The New South Wales Snapshot programmes targets maternity, alcohol and drugs, child and family health and mental health services.

occurring at the national level. These include the revised family violence guideline,[2] implementation of the National Child Protection Alert System and Children's Teams[c]. The revised New Zealand Family Violence Assessment and Intervention Guideline (2016),[2] which includes a Child Protection Checklist tool to support clinical judgement, provides a policy direction for normalising clinical assessment for child abuse and neglect. We also acknowledge the work programme of the Ministerial Group on Family Violence and Sexual Violence[3] including the Integrated Safety Response being piloted in Christchurch and Waikato.

There is work being done at all levels to improve the health response to family violence. However, the data in this report identify a gap between policy and practice. Programme sustainability is a concern. Turnover of key VIP staff including DHB VIP portfolio managers, family violence intervention coordinators and service level champions impact on VIP service delivery within individual DHBs. There is insufficient focus on the effectiveness of services for Māori. Ongoing workforce development, strong management support, and more capability in applying the Model for Improvement are still needed. The lack of electronic records for family violence results in a significant burden of manual chart review.

Having data is only a first step in improving quality. Understanding the "causes underlying the differences and determining what actions may be appropriate to take to improve health outcomes"[48] remains our challenge. The response to family violence is not a tick box affair. It demands a supportive system with a skilled workforce sensitive to the dynamics of family violence, including the entanglement between intimate partner violence and child abuse and neglect and the family harm caused by a pattern of coercive and controlling behaviours.[49,50] This is an essential if we are to meet our obligation to prevent and reduce the harm of family violence.[51]

EVALUATION STRENGTHS AND LIMITATIONS

Strengths of this evaluation project include using established family violence programme evaluation instruments and following standard quality improvement processes in auditing.[25,52] The project promotes a comprehensive systems approach to addressing family violence, a key characteristic for delivering effective services.[10]

The VIP Snapshot audits provide standardised data that can be aggregated across all DHBs and utilised for accountability purposes and performance measurement. DHBs will be supported to improve their internal systems over time to meet the standardised requirements of the VIP Snapshot clinical audits. This will result in more efficient and effective VIP Clinical Snapshot audits in DHBs in the future.

Our processes of audit planning and reporting have facilitated DHB VIP programme development over time. The evaluation project is also integrated into the VIP management programme, providing the Ministry the ability to target remedial actions in the context of limited resources.

The audit rounds foster a sense of urgency,[53] supporting timely policy revisions, procedure endorsements and timely filling of unfilled vacancies of FVI Coordinator positions. Finally, and perhaps most importantly, the longitudinal nature of the evaluation has allowed monitoring of change over time (2004 to 2015).

Limitations are important to consider in interpreting the findings and making recommendations based on this evaluation work. These include:

- By design, this study is limited to DHBs providing acute hospital and community services at

[c] http://childrensactionplan.govt.nz/childrens-teams/

secondary and tertiary public hospitals. The VIP does not include services provided by private hospitals which may also provide publicly funded services, or primary care where family violence prevention programmes are being introduced opportunistically in DHB regions.

- Infrastructure audit tool scores range from 0 to 100. This means that as programmes mature they approach the top end of the scale and have little room for score improvement, creating a 'ceiling effect'. In addition, some infrastructure indicators have become 'out of date', such as the partner abuse programme tool requiring monthly (rather than quarterly) governance (steering group) meetings. The infrastructure tools are under review to guide programme maintenance and sustainability.

- The 2015 VIP Delphi audit does not include indicators associated with changes in the revised (2016) Family Violence Assessment and Intervention Guideline: Child Abuse And Intimate Partner Violence,[2] the Family Violence Intervention Guidelines: Elder Abuse and Neglect[44] or the Shaken Baby Prevention Programme.

- The Snapshot audit does not capture all recommended family violence screening, such as for male patients presenting with signs or symptoms indicative of abuse or in the primary care setting.

- The Snapshot sample size for individual DHBs was small (n=25). For example, a DHB may have assessed for abuse in 10 out of 25 eligible cases, with only a single disclosure/identification.

VIP PRIORITIES FOR 2016 – 2018

- VIP to be fully implemented in all Ministry of Health targeted services in all DHBs

- DHBs to focus on improving the consistency and quality of identification, assessment, and intervention for children, women, their families/whānau experiencing family violence.

- A Delphi study is being conducted to update the current VIP Delphi Partner Abuse and Child Abuse and Neglect audit tools. The aim is to identify best practice elements of a health response to family violence informed by current literature, the refreshed Family Violence Assessment and Intervention Guideline: Child Abuse and Intimate Partner Violence 2016, the New Zealand health context, and programme innovations (e.g. Elder Abuse, Shaken Baby Programme).

- Standardised national IT solutions to enable electronic monitoring of VIP by DHB and services.

- VIP will continue to contribute to and support all government initiatives and interventions to reduce child abuse and neglect and family violence.

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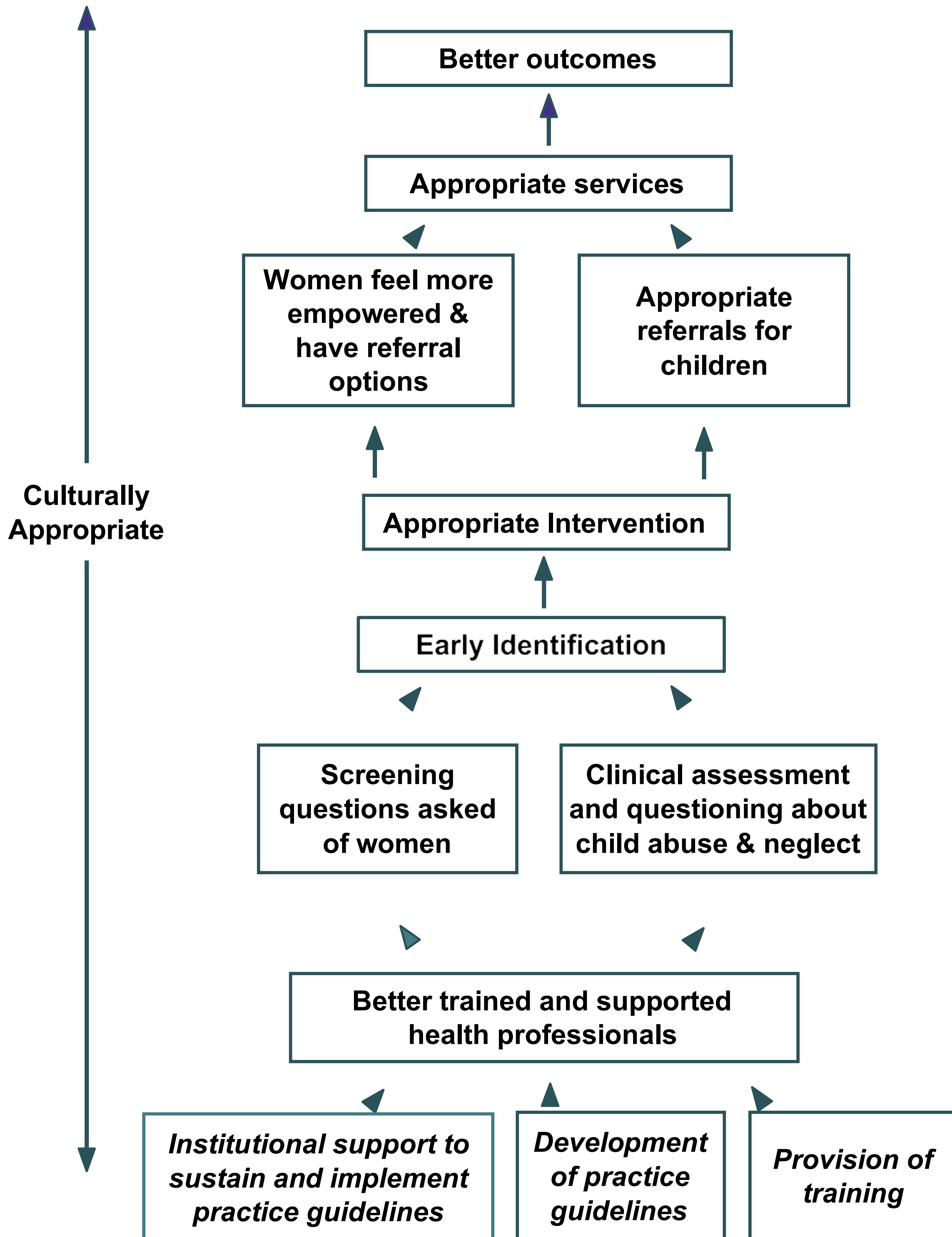
APPENDICES

APPENDIX A: Family Violence Programme Logic[a]



[a] MOH Advisory Committee; modified from Duignan, Version 4, 16-10-02

APPENDIX B: District Health Board Hospitals

District Health Board	Hospital	Level of care
Northland	Kaitaia	**S**
	Whangarei	**S**
Waitemata	North Shore	**S**
	Waitakere	**S**
Auckland	Auckland City	**T**
Counties Manukau	Middlemore	**T**
Waikato	Waikato	**T**
	Thames	**S**
Bay of Plenty	Tauranga	**S**
	Whakatane	**S**
Lakes	Rotorua	**S**
Tairawhiti	Gisborne	**S**
Taranaki	New Plymouth	**S**
Hawkes Bay	Hawkes Bay	**S**
Whanganui	Whanganui	**S**
MidCentral	Palmerston North	**S**
Capital and Coast	Wellington	**T**
Wairarapa	Wairarapa	**S**
Hutt Valley	Hutt	**S**
Nelson-Marlborough	Nelson	**S**
	Wairau	**S**
Canterbury	Christchurch	**T**
	Ashburton	**S**
West Coast	Grey Base	**S**
South Canterbury	Timaru	**S**
Southern	Otago	**T**
	Southland	**S**

Links to DHB Maps: **http://www.moh.govt.nz/dhbmaps**

APPENDIX C: VIP Snapshot Audit Information Sheet

(Letterhead removed)

VIP Snapshot Information

1. Introduction

The VIP Snapshot clinical audit system has been redeveloped to provide a more efficient and user-friendly audit tool.

2. Overview

The VIP Snapshot's primary purpose is to provide measurement data of DHB VIP Intimate Partner Violence (IPV) routine enquiry (screening) in selected services and Child Abuse and Neglect (CAN) risk assessments data for accountability purposes.
VIP snapshot clinical audits indicate a shift in national VIP evaluation focus from DHB infrastructure development to accountability and improvements in the delivery of services to vulnerable children, women, their whānau and families.

3. Timeframe

The due date is 7 November 2015.

4. 2015 VIP Snapshot Clinical audit

The following services have been selected for the 2015 VIP snapshot audit.

A. Intimate Partner Violence (IPV):

- Postnatal Maternity Admissions
- Adult Emergency Department
- Child Health inpatient (aged 0-16 years) - Female guardians, parents or caregivers assessed for IPV
- Sexual Health services

B. Child Abuse and Neglect Risk Assessment:

- All children aged under two presenting to Emergency Department for any reason

5. Sites:

- Main sites only should be reported on if there are satellite sites and many services.

6. Audit Period:

The 3 month audit period is from 1 April to 30 June 2015.

7. User names and Passwords

The VIP Snapshot system will be emailing you with user names and a temporary password. You will be required to create a new password for the system.
Access the VIP Snapshot system at https://vipsnapshot.aut.ac.nz

8. Random Sample

Random samples of 25 patient health records are to be retrospectively selected from all eligible persons during the review period (1 April – 30 June) for each of the five services listed above.

The Quality Manager, Clinical Records or IT Help should assist in the random selection process. Refer to the VIP Tool Kit document "How to select an audit sample".

9. Definitions

Definitions are provided in Appendix 1. They are also available in the Snapshot system drop down menu.

10. Adhoc and Official Audits

The new system was developed for the official Snapshot Audit data collection (1 April – 30 June). You will also be able to use the system to enter DHB VIP data from Adhoc audits. Please tick the correct category.

11. Start a New Audit

1. Click on the **+ New Audit** button
2. Click whether the Official (required Snapshot Audit) or an Adhoc (voluntary) audit
3. Select your DHB from the drop down list (DHBs ordered north to south)
4. Enter the percent of current staff who have completed VIP core training by profession (e.g. doctor, nurse, midwife, social worker).
5. Enter the total number of eligible women / children who were admitted during the audit period (It is from this number that 25 patients should be randomly selected)
6. Click 'save' to advance to patient data entry

12. Enter patient data

1. Click Ethnicity/ies as recorded in the patient file
2. IPV Screen / Child Protection Screen – Yes/No
    a. If tick No, save and move onto next patient file.
    b. If tick yes, go to IPV Disclosed / Child Protection Concern
        i. If tick no, save and move onto next patient file
        ii. If tick yes, go to IPV Referral /CAN Consultation
            1. Tick Yes or No, save and move onto next patient.
3. The number of files entered and saved appears on the right side of the screen.
4. 25 patient files to be entered for each service.
5. The system will automatically switch over to audit status "DONE" for Official (required Snapshot Audit) when input is complete. (Adhoc (voluntary) audits need to be manually switched over by clicking "In Progress" to "DONE").
6. You may enter the data in one or more sittings. The system will keep track of how many patients you have entered.
7. If you are entering a smaller number of cases for an ad hoc audit you may click the "In Progress" button to change to "DONE".

13. Your Results

The system will provide the DHB results (screening and disclosure/concern and referral/consultation). Document your results for each service in your Self Audit Report and include in your January 2016 report to the Ministry of Health.

APPENDIX 1. DEFINITIONS

Generic Questions:

VIP Core Training:
Enter the percent of current staff who have completed VIP Core Training in designated service:

Ethnicity: Select Ethnicity/ies as indicated in patient file.

INTIMATE PARTNER VIOLENCE

POSTNATAL MATERNITY

Total number of women who have given live birth and who have been admitted to postnatal maternity ward during audit period.

IPV Screen: Was the woman screened?

NO: There is no documentation that the woman was screened. If there is documentation regarding a reason for not screening (such as 'with' partner), this is still a 'NO'.

YES: There is documentation that the woman was screened for partner abuse in the past 12 months according to the national VIP Guidelines. This would include asking the woman three or more screening questions.

IPV Disclosed: Did the woman disclose IPV?

NO: Woman did not disclose IPV. If a woman was screened, but there is no documentation regarding disclosure, this is a 'NO'.

YES: Woman disclosed abuse in response to IPV screen (abuse in the past 12 months or currently afraid). If woman disclosed abuse before screening, would still be a 'YES'.

IPV Referrals: Were appropriate referrals made?

NO: No identification in notes that referrals were discussed, or notes indicate referrals were made, but do not specify to whom, or appear incomplete. If documented that a woman refused a referral, this is also a NO.

YES: offsite: Clear evidence in notes of appropriate referrals to offsite specialised family violence support. This would include, for example, providing the woman with a brochure with contact or website information to offsite services (e.g. Women's Refuge, community services).

YES: onsite: Immediate access to onsite family violence specialist (such as a social worker, Women's Refuge advocate) who establishes safety, addresses identified risks, and provides support and access to community services.

ADULT EMERGENCY DEPARTMENT

Information requested included:

Enter total number of all women aged 16 years and over who presented to ED during

the audit period.

Age: Enter age of woman

Triage – 1, 2, 3, 4, or 5 (Click Triage status)

Admitted to intensive care, coronary care, or high dependency unit: YES/NO

IPV Screen: Was the woman screened?

NO: There is no documentation that the woman was screened. If there is documentation regarding a reason for not screening (such as 'with' partner), this is still a 'NO'.

YES: There is documentation that the woman was screened for partner abuse in the past 12 months according to the national VIP Guidelines. This would include asking the woman three or more screening questions.

IPV Disclosed: Did the woman disclose IPV?

NO: Woman did not disclose IPV. If a woman was screened, but there is no documentation regarding disclosure, this is a 'NO'.

YES: Woman disclosed abuse in response to IPV screen (abuse in the past 12 months or currently afraid). If woman disclosed abuse before screening, would still be a 'YES'.

IPV Referrals: Were appropriate referrals made?

NO: No identification in notes that referrals were discussed, or notes indicate referrals were made, but do not specify to whom, or appear incomplete. If documented that a woman refused a referral, this is also a NO.

YES: offsite: Clear evidence in notes of appropriate referrals to offsite specialised family violence support. This would include, for example, providing the woman with a brochure with contact or website information to offsite services (e.g. Women's Refuge, community services).

YES: onsite: Onsite family violence specialist (such as a social worker, Women's Refuge advocate) who establishes safety, addresses identified risks, and provides support and access to community services.

SEXUAL HEALTH

Enter total number of all women aged 16 years and over who presented to Sexual Health Services during the audit period.

IPV Screen: Was the woman screened?

NO: There is no documentation that the woman was screened. If there is documentation regarding a reason for not screening (such as 'with' partner), this is still a 'NO'.

YES: There is documentation that the woman was screened for partner abuse in the past 12 months according to the national VIP Guidelines. This would include asking the woman three or more screening questions.

IPV Disclosed: Did the woman disclose IPV?

NO: Woman did not disclose IPV. If a woman was screened, but there is no documentation regarding disclosure, this is a 'NO'.

YES: Woman disclosed abuse in response to IPV screen (abuse in the past 12 months or currently afraid). If woman disclosed abuse before screening, would still be a 'YES'.

IPV Referrals: Were appropriate referrals made?

NO: No identification in notes that referrals were discussed, or notes indicate referrals were made, but do not specify to whom, or appear incomplete. If documented that a woman refused a referral, this is also a NO.

YES: offsite: Clear evidence in notes of appropriate referrals to offsite specialised family violence support. This would include, for example, providing the woman with a brochure with contact or website information to offsite services (e.g. Women's Refuge, community services).

YES: onsite: Onsite family violence specialist (such as a social worker, Women's Refuge advocate) who establishes safety, addresses identified risks, and provides support and access to community services.

CHILD HEALTH INPATIENT

Enter total number of child health admissions aged 16 years and under, admitted to a general paediatric inpatient ward (not a specialty setting) during the audit period

Age of Child: Enter child's age at last birthday. Please enter '0' for children under 1 year.

Ethnicity: Select ethnicity/ies as indicated in child's file

IPV Screen: **Was the female caregiver (guardian, parent or caregiver) screened?**

NO: There is no documentation that the woman was screened. If there is documentation of a reason for not screening (such as 'with partner' this is still a NO.

NO, female caregiver Documentation states there is no female caregiver in the household.

YES: There is documentation that the woman was screened for IPV in the past 12 months according to the national VIP Guidelines. This would include asking the woman three or more screening questions.

IPV Disclosed: Did the woman disclose IPV?

NO: Woman did not disclose IPV. If a woman was screened, but there is no documentation regarding disclosure, this is a 'NO'.

YES: Woman disclosed abuse in response to IPV screen (abuse in the past 12 months or currently afraid). If woman disclosed abuse before screening, would still be a 'YES'.

IPV Referrals: Were appropriate referrals made?

NO: No identification in notes that referrals were discussed, or notes indicate referrals were made, but do not specify to whom, or appear incomplete. If documented that a woman refused a referral, this is also a NO.

YES: offsite: Clear evidence in notes of appropriate referrals to offsite specialised family violence support. This would include, for example, providing the woman with a brochure with contact or website information to offsite services (e.g. Women's Refuge, community services).

YES: onsite: Onsite family violence specialist (such as a social worker, Women's Refuge advocate) who establishes safety, addresses identified risks, and provides support and access to community services.

CHILD ABUSE & NEGLECT

Ethnicity: Select ethnicity/ies as indicated in child's file

Thorough Child Protection Screen /Risk Assessment - Was a thorough Child Protection Screen or Assessment done?

NO: No evidence of a thorough Child Protection screen, checklist or flowchart (i.e. no child injury flowchart, checklist or equivalent in the notes, or documentation is present but is blank, or is partially completed).

YES: Evidence of a thorough Child Protection Screen/Risk Assessment (i.e. Child Injury Flowchart, checklist or equivalent fully completed including legible signature.

CAN Concern – Was a Child Protection Concern identified?

NO: No child protection concerns or risk factors of child abuse and neglect were documented; or documentation was not complete.

YES: A Child Protection Concern (i.e. one or more risk factors) is identified in the notes. If documentation of a Report of Concern, suspected child maltreatment or child protection concern is included in the notes, this would be a YES.

CAN Consultation: Were identified Child Protection concerns discussed?

NO: No indication of discussion in the notes about Child Protection risk factors and assessment, or the plan appears inappropriate, unclear or misleading, or notes indicate clear plan but do not indicate who the case was discussed with. If no CAN concern, this is a 'NO'.

YES: Evidence that Child Protection consultation occurred is in the notes with name and designation of person consulted. Child Protection Consultation may be with a Senior Consultant ED, Paediatrician, specialist social worker, CYF, or other member of the multidisciplinary child protection team. Discussion of the Child Protection risk factors, assessment of the level of risk and plan is recorded.

APPENDIX 2. SCREENING QUESTIONS

The VIP Partner Abuse Intervention Training (2014) suggests the following Screening Questions and framing be used to screen women patients: (Fanslow (2002) FVIG p43 (2.1.4))

"The staff of this service are concerned about family violence, and the impact it has on women and children, therefore we routinely ask all women about violence in their home."

- 'Have you been hit, kicked, punched or hurt in any way by someone in the last year?'
- 'Do you feel safe in your current relationship?'
- 'Is there a partner from a previous relationship who is making you feel unsafe now?'
- 'Within the last year has anyone forced you to have sex in a way you didn't want to?'

OR ask how the partner is finding being a parent and whether anything has changed in the woman's relationship.

- "How are things between you?"

OR you might have to refer to marks on the woman's body or behaviour and say

- "I've noticed that ………. Is someone hurting you?" or
- I'm worried that you might be being hit or yelled at."

APPENDIX 3. REFERENCES

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APPENDIX D: DHB Self Audit Report: 2015 Follow-up Form

Violence Intervention Programme (VIP) Evaluation

***Self Audit Report**: 2015 (for the period 1 July 2014 – 30 June 2015)*

** District Health Board

** Hospital(s)

** ** 2015

Chief Executive Officer
VIP Sponsor / Portfolio Manager
FVIC
Child Protection Coordinator

VIP Implementation (Roll out of integrated partner abuse and child abuse and neglect)

Service	VIP Implemented (Please tick YES or NO)		Comment
	YES	NO	
1. Emergency Department			
2a. Child Health – Inpatient			
2b. Child Health – Community			
3a. Maternity – Inpatient			
3b. Maternity – Community			
4. Sexual Health – Community			
5a. Mental Health – Inpatient			
5b. Mental Health – Community			
6. Alcohol & Drug – Community			

DHB Violence Intervention Programme Self Audit Summary

This report provides an analysis based on review of the following (tick all that apply):
____Current VIP strategic plan and 2014-15 action plan
____Partner Abuse Programme Overall and Category Scores (using Delphi tool)
____Child Abuse and Neglect Programme Overall and Category Scores (using Delphi tool)
____VIP Snapshot Clinical Audit results (using online Snapshot findings)
____Internal clinical audit results (using VIP QI Toolkit)
____2014-2015 completed PDSA cycles
____Completed Supplementary Information (see page 4)

Self Audit Findings and Observations

Most significant VIP achievements since the last audit:

Programme Strengths

Areas for Improvement:

Overall Audit Conclusions:

Consider:

- *Evaluation scores*
- *VIP Snapshot results*
- *Maori Responsiveness*
- *Progress since previous audit*
- *Proposed Actions for 2015*

Titles for Selected 2015-2016 Model for Improvement PDSAs (Plan-Do-Study-Act):

1.

2.

Self Audit Report Approval:

DHB Violence Intervention Programme Audit Team Leader

________________________	____________________________	_______________
Name	**Signature**	**Review Date**

DHB Violence Intervention Programme Sponsor

________________________	____________________________	_______________
Name	**Signature**	**Review Date**

SUPPLEMENTARY INFORMATION
(Please complete and submit with self audit report)

1. *Cultural responsiveness to Māori and contribution to whānau ora workforce development*

Does your VIP strategic plan identify actions to improve cultural responsiveness to Māori and to contribute to whānau ora workforce development? YES / NO *(Delete one)*

Please elaborate on Whānau Ora initiative progress and plans:

2. *Elder Abuse and Neglect intervention and violence prevention policies*

Have Elder Abuse and Neglect (EAN) policies been approved? YES / NO *(delete one)*
Are the policies being implemented? YES / NO *(delete one)*

Please elaborate:

3. *Disability initiatives*

Has your programme addressed issues for persons with disabilities? YES / NO *(Delete one)*

Please elaborate:

4. *Shaken Baby Programme Implementation*

Is the implementation of the Shaken Baby Programme underway? YES / NO *(Delete one)*

Please elaborate:

5. *Clinical Audit: Documentation audit of referrals made by DHB to Child Youth and Family (refer to VIP QI Toolkit)*

Review Period Start (dd/mm/yy)	
Review Period End (dd/mm/yy)	
No. *Report of Concern*s made by DHB to CYF during period	
No. *Report of Concern*s and accompanying health records Reviewed	
No. include assessment for co-occurrence of partner abuse	
No. child maltreatment confirmed or suspected included in health diagnosis	
No. child protection concerns included in discharge summary	

Comments:

APPENDIX E: Delphi Scoring Weights

The reader is referred to the original Delphi scoring guidelines available at: http://www.ahcpr.gov/research/domesticviol/.

The weightings used for this study are provided below.

Domain	Partner Abuse	Child Abuse & Neglect	Revised Child Abuse & Neglect
1. Policies and Procedures	1.16	1.16	1.21
2. Physical Environment	0.86	0.86	.95
3. Institutional Culture	1.19	1.19	1.16
4. Training of staff	1.15	1.15	1.16
5. Screening and Safety Assessment	1.22	N/A	N/A
6. Documentation	0.95	0.95	1.05
7. Intervention Services	1.29	1.29	1.09
8. Evaluation Activities	1.14	1.14	1.01
9. Collaboration	1.04	1.04	1.17
10. Safety and Security	N/A	N/A	1.20

Total score for Partner Abuse= sum across domains (domain raw score * weight)/10
Total score for Child Abuse & Neglect = sum across domains (domain raw score*weight)/8.78

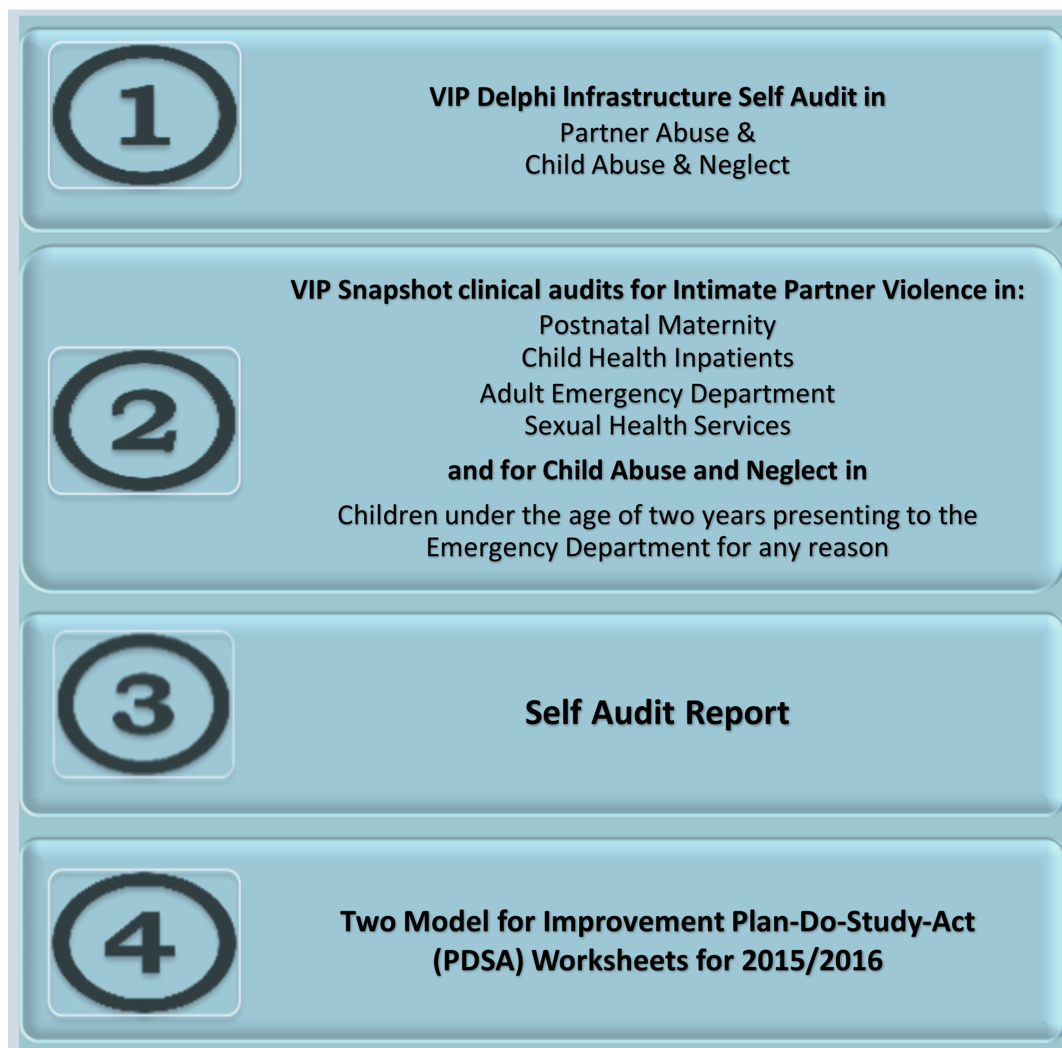
APPENDIX F: 2015 Audit Round Process

VIP AUDIT PREPARATION INFORMATION
2015 Evaluation

Introduction

The VIP evaluation provides the opportunity for DHBs to build competence in family violence service delivery as well as measure progress over time. Processes are guided by a philosophy of supporting programme leaders in building a culture of improvement. The evaluation project is approved by the Multi-region Ethics Committee (AKY/03/09/218) with current approval to December 2015.

It is recommended that requirements of the 2015 VIP audit are completed in the following order.



The 2015 VIP audit covers the one year period 1 July 2014 to 30 June 2015 (not to be confused with the Snapshot audit three month period from 1 April to 30 June 2015).

Due Dates

28 October	VIP Delphi Audits due
7 November	VIP Snapshot Audits – data entry to be completed
7 November	Self Audit Report due
7 November	Two PDSA – PLANS only –due for evaluation team review
7 April 2016	Two completed PDSA worksheets (with *DO, STUDY* and *ACT)* due

Preliminary 2015 VIP Audit national results will be shared at the NNVIP Meeting (23 November in Wellington)

Audit Preparation

We encourage the development of an Audit Plan to guide your evaluation processes. The plan is ideally developed in collaboration with the DHB VIP portfolio manager, steering group (including Quality & Risk, Māori Health) and Family Violence Intervention Coordinator(s). The following resource may assist you in effective self audit planning: Making an Audit Plan 2015 (Making a Self Audit Plan 2015.pdf).

VIP Delphi Infrastructure Self-Audits

- Preparation for the Delphi excel tool audits should build on previous audit documentation, updating and improving evidence collation.
- If required, blank partner abuse and child abuse and neglect audit files are available to download at www.aut.ac.nz/vipevaluation or from the VIP HIIRC website.
- A Physical Environment Walk Through Form is also available (VIP Physical environment walkthrough.pdf)
- Please submit your PA and CAN Delphi audits to Christine McLean by 28 October.

VIP Snapshot Clinical Audits

The Snapshot audits are nationally standardised to measure service delivery to vulnerable children and women, whānau and families. In 2015 the VIP Snapshot system has been upgraded. Users will be able to save and edit data and receive their audit results in real time.

- Sample size: Retrospective random samples of 25 patient health records are to be selected from the 3 month review period – 1 April to 30 June 2015 from 5 services:

  IPV:

  - Postnatal Maternity

- Child Health Inpatient
- Sexual Health Services
- Adult Emergency Department

CAN:

- Children's/Emergency Department – All children under the age of two admitted to ED for any reason.

- The VIP Snapshot system will email all FVICs with user name and a temporary password. You will be required to create a password for the system.
- Access the VIP Snapshot system at https://vipsnapshot.aut.ac.nz
- Medical Records should be advised as soon as possible of the audit requirements for each service
- Snapshot audits are to be undertaken in all services whether or not VIP is implemented
- Please enter your VIP Snapshot data by 7 November 2015

Self Audit Report

- The Self Audit Report covers the one year period 1 July 2014 to 30 June 2015.
- Please provide the names of the key DHB VIP stakeholders on the cover sheet, and complete the Self Audit Findings and Evaluations, and the Supplementary Information sections as requested.
- Please double-check that all items have been completed.

Model for Improvement Plan-Do-Study-Act (PDSA) Worksheets

- Two PDSA Plans are to be submitted by 7 November for approval by the AUT Evaluation Team **prior** to implementation
- The Objectives should focus on ***improving your Snapshot results.***
- PDSA pack with resources and instructions will be forwarded separately.
- Completed PSDA worksheets (with *DO, STUDY* and *ACT)* submitted by 7 April 2016.

Additional Information

Independent Audit

The criteria for an independent audit (outlined in the 2015-2018 Ministry of Health Contract for the National Evaluation of District Health Board Responses to Victims of Family Violence) is when the DHB's Delphi overall or domain (category) score is less than 80. If an Independent Audit is triggered, indicator evidence (as prepared for the self-audit) will need

to be available to be viewed by the independent evaluator.
National Report. A national report and summary documenting VIP programme development across the audit period will be made available in April 2016. Audit discussions and individual DHB reports provided by auditors will be kept confidential between the DHB and MOH VIP team. **National reports of overall programme and cultural responsiveness scores will identify DHBs in league tables. DHBs achieving high scores in the VIP Snapshot audits will be named in the National Report.**

Audit Support
Audit support is available through various means. Regional FVICs should be your first point of contact. Please feel free to get help from the audit team, Chris McLean – in the first instance, and Jane Koziol-McLain, to answer any outstanding questions.

Concerns: For concerns regarding the process or conduct of the audit please contact Jane Koziol-McLain or the Ministry of Health contact person, Helen Fraser (07) 929 3647 or Helen_Fraser@moh.govt.nz

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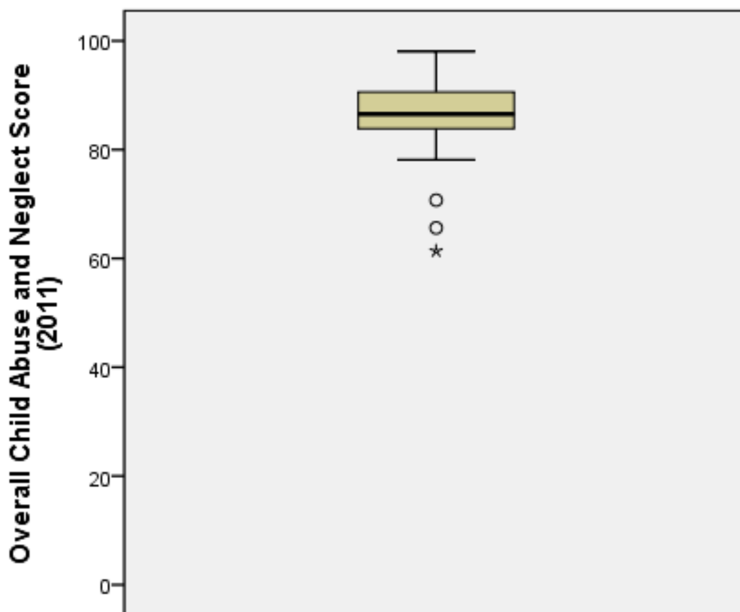
APPENDIX G: How to Interpret Box Plots



- The length of the box is important. The lower boundary of the box represents the 25th percentile and the upper boundary of the box the 75th percentile. This means that the box includes the middle half of all scores. So, 25% of scores will fall below the box and 25% above the box.
- The thick black line indicates the middle score (median or 50th percentile). This sometimes differs from the mean, which is the arithmetic average score.
- A circle indicates an 'outlier', a value that is outside the general range of scores (1.5 box-lengths from the edge of a box).
- A star indicates an 'extreme' score (3 box-lengths from the edge of a box).
- The whiskers or needles extending from the box indicate the score range, the highest and lowest scores that are not outliers (or extreme values).

SPSS

APPENDIX H. Partner Abuse Baseline and Follow-Up Scores

	Median										Achieving Target Score ≥ 70									≥ 80
	2004	2005	2007	2008	2009	2011	2012	2013	2014	2015	2004	2005	2007	2008	2009	2011	2012	2013	2014	2015
Overall Score	20	28	49	67	74	84	91	92	92	**92**	1 (4%)	2 (8%)	5 (19%)	13[a] (48%	15 (56%)	25 (93%)	27 (100%)	19 (95%)	20 (100%)	**19 95%**
Domain Scores																				
Policies & Procedures	19	30	49	62	75	82	87	89	87	**87**	1 (4%)	2 (8%)	7 (26%)	11 (41%)	16 (59%)	20 (74%)	24 (89%)	18 (90%)	19 (95%)	**18 (90%)**
Physical Environment	7	15	23	75	79	91	100	100	100	**100**	0 (0%)	1 (4%)	4 (15%)	16 (59%)	16 (59%)	23 (85%)	25 (93%)	18 (90%)	19 (95%)	**17 (85%)**
Institutional Culture	22	31	59	72	83	89	94	97	94	**92**	2 (8%)	5 (20%)	8 (30%)	15 (56%)	16 (59%)	23 (85%)	25 (93%)	18 (90%)	19 (95%)	**17 (85%)**
Training of Providers	11	32	59	78	88	89	100	100	100	**100**	1 (4%)	5 (20%)	8 (30%)	15 (56%)	18 (67%)	26 (96%)	26 (96%)	19 (95%)	20 (100%)	**19 (95%)**
Screening & Safety Assessment	0	0	43	65	73	80	80	854	87	**88**	1 (4%)	5 (20%)	8 (30%)	15 (56%)	18 (67%)	26 (96%)	26 (96%)	19 (95%)	**20 (100%)**	**19 (95%)**
Documentation	0	19	29	67	76	90	91	90	100	**95**	0 (0%)	0 (0%)	2 (7%)	12 (44%)	14 (52%)	22 (82%)	24 (89%)	18 (90%)	**18 (90%)**	**17 (85%)**
Intervention Services	26	46	62	65	79	93	100	100	97	**99**	4 (16%)	6 (24%)	9 (33%)	11 (41%)	17 (63%)	24 (89%)	27 (100%)	20 (100%)	20 (100%)	**19 (95%)**
Evaluation Activities	0	0	20	34	63	66	80	80	90	**82**	1 (4%)	1 (4%)	4 (15%)	6 (22%)	11 (41%)	13 (48%)	23 (85%)	14 (70%)	**15 (75%)**	**15 (75%)**
Collaboration	38	77	79	93	92	100	100	100	100	**100**	1 (4%)	15 (60%)	19 (70%)	23 (85%)	25 (93%)	27 (100%)	27 (100%)	20 (100%)	20 (100%)	**20 (100%)**

Note: The unit of analysis changed from hospitals (n=27) to DHBs (n=20) for the 2013 follow-up audit. The selected benchmark score was raised from 70 to 80 for the 2015 follow-up audit. The 2012 follow-up scores include independent scores (n=13 hospitals) and self audit scores (n=14 hospitals). The 2013 and 2014 follow-up scores include self audit scores (n=16) and independent audit scores (n=4). The 2015 follow-up scores are all (n=20) from self audits.

APPENDIX I: Partner Abuse Delphi Item Analysis

Note: 120 month follow-up scores include self audit scores (n=16 DHBs) and independent audit scores (n=4 DHBs). Note: The 96 month follow-up scores were hospital based including self audit scores (n=14 hospitals) and independent audit scores (n=13 DHBs).

	"YES" responses	**108 mo FU DHBs (%)**	**120 mo FU DHBs (%)**	**2015 FU DHBs**
CATEGORY 1. POLICIES AND PROCEDURES				
1.1	Are there official, written hospital policies regarding the assessment and treatment of victims of partner abuse? If yes, do policies:	19 (95%)	20 (100%)	**20 (100%)**
	a) define partner abuse?	20 (100%)	20 (100%)	**20 (100%)**
	b) mandate training on partner abuse for any staff?	20 (100%)	19 (95%)	**19 (95%)**
	c) advocate universal screening for women anywhere in the hospital?	20 (100%)	20 (100%)	**20 (100%)**
	d) define who is responsible for screening?	20 (100%)	20 (100%)	**20 (100%)**
	e) address documentation?	19 (95%)	20 (100%)	**19 (95%)**
	f) address referral of victims?	20 (100%)	20 (100%)	**20 (100%)**
	g) address legal reporting requirements?	19 (95%)	20 (100%)	**20 (100%)**
	h) address the responsibilities to, and needs of, Māori?	20 (100%)	20 (100%)	**20 (100%)**
	i) address the needs of other (non-Māori/non-Pakeha) cultural and/or ethnic groups?	19 (95%)	20 (100%)	**20 (100%)**
	j) address the needs of LGBT clients?	19 (95%)	19 (95%)	**18 (90%)**
1.2	Is there evidence of a hospital-based partner abuse working group? If yes, does the group:	20 (100%)	19 (95%)	**19 (95%)**
	a) meet at least every month?	11 (55%)	13 (65%)	**8 (40%)**
	b) include representative(s) from more than two departments?	20 (100%)	19 (95%)	**20 (100%)**
	c) include representative(s) from the security department?	15 (75%)	16 (80%)	**16 (80%)**
	d) include physician(s) from the medical staff?	17 (85%)	17 (85%)	**17 (85%)**
	e) include representative(s) from a partner abuse advocacy organization (e.g. Women's Refuge)?	18 (90%)	19 (95%)	**19 (95%)**
	f) include representative(s) from hospital administration?	20 (100%)	19 (95%)	**20 (100%)**
	g) include Māori representative(s)?	20 (100%)	19 (95%)	**20 (100%)**
1.3	Does the hospital provide direct financial support for the partner abuse programme (beyond VIP funding)?	17 (85%)	17 (85%)	**20 (100%)**
1.3a	Is funding set aside specifically for Māori programmes and initiatives?	13 (65%)	12 (60%)	**11 (55%)**
1.4	Is there a mandatory universal screening policy in place?	20 (100%)	20 (100%)	**20 (100%)**

	"YES" responses	**108 mo FU DHBs (%)**	**120 mo FU DHBs (%)**	**2015 FU DHBs**
1.5	Are there quality assurance procedures in place to ensure partner abuse screening?	19 (95%)	20 (100%)	**20 (100%)**
	a) regular chart audits to assess screening?	18 (90%)	20 (100%)	**20 (100%)**
	b) positive reinforcers to promote screening?	16 (80%)	19 (95%)	**19 (95%)**
	c) is there regular supervision?	18 (90%	18 (90%)	**18 (90%)**
1.6	Are there procedures for security measures to be taken when victims of partner abuse are identified? If yes,			
	a) written procedures that outline the security department's role in working with victims and perpetrators?	17 (85%)	19 (95%)	**20 (100%)**
	b) procedures that include name/phone block for victims admitted to hospital?	17 (85%)	16 (80%)	**18 (90%)**
	c) procedures that include provisions for safe transport from the hospital to shelter?	17 (85%)	18 (90%)	**18 (90%)**
	d) do these procedures take into account the needs of Māori?	15 (75%)	18 (90%)	**19 (95%)**
1.7	Is there an identifiable partner abuse coordinator at the hospital? If yes is it a: (*choose one*)	20 (100%)	20 (100%)	**20 (100%)**
	a) part time position or included with other responsibilities?	6 (30%)	6 (30%)	**8 (40%)**
	b) full-time position with no other responsibilities?	14 (70%)	14 (70%)	**12 (60%)**
CATEGORY 2. PHYSICAL ENVIRONMENT				
2.1	In how many locations are posters/brochures related to partner abuse on display in the hospital? (up to 35):			
	11-20	2 (10%)	0 (0%)	**1 (5%)**
	21-35	18 (90%)	20 (100%)	**19 (95%)**
	In how many locations are there Māori images related to partner abuse on display? (up to 17):			
	1-10	0 (0%)	0 (0%)	**1 (5%)**
	11-17	20 (100%)	20% (100%	**19 (95%)**
2.2	In how many locations is there referral information related to partner abuse services on display in the hospital? (Can be included on the posters/brochure noted above)(up to 35):			
	11-20	2 (10%)	2 (10%)	**2 (10%)**
	21-35	18 (90%)	18 (90%)	**18 (90%)**
	In how many locations is there referral information related to Māori providers of partner abuse services on public display in the hospital? (up to 17):			
	0-10	3 (15%)	4 (20%)	**2 (10%)**
	11-17	17 (85%)	16 (80%)	**18 (90%)**
	In how many locations is there referral information re non- Māori non-Pakeha on public display? (up to 17)			
	0-6	4 (20%)	5 (25%)	**2 (10%)**
	7-17	16 (80%)	15 (75%)	**18 (90%)**

	"YES" responses	108 mo FU DHBs (%)	120 mo FU DHBs (%)	2015 FU DHBs (%)
2.3	Does the hospital provide temporary (<24 hours) safe shelter for victims of partner abuse who cannot go home or cannot be placed in a community-based shelter? If yes:	20 (100%)	20 (100%)	20 (100%)
	a) Does the design and use of the safe shelter support Māori cultural beliefs and practices?	19 (95%)	19 (95%)	18 (90%)
CATEGORY 3. INSTITUTIONAL CULTURE				
3.1	In the last 3 years, has there been a formal (written) assessment of the hospital staff's knowledge and attitude about partner abuse? If yes, which groups have been assessed?			
	a) nursing staff	20 (100%)	19 (95%)	**18 (90%)**
	b) medical staff	16 (80%)	15 (75%)	**15 (75%)**
	c) administration	16 (80%)	16 (80%)	**12 (60%)**
	d) other staff/employees	18 (90%)	17 (85%)	**17 (85%)**
	If yes, did the assessment address staff knowledge and attitude about Māori and partner abuse?	16 (80%)	19 (95%)	**15 (75%)**
3.2	How long has the hospital's partner abuse programme been in existence?			
	1-24 months	0 (0%)	0 (0%)	**0 (0%)**
	24-48 months	0 (0%)	0 (0%)	**0 (0%)**
	>48 months	20 (100%)	20 (100%)	**20 (100%)**
3.3	Does the hospital address the following in responding to employees experiencing partner abuse?			
	a) Is there a hospital policy covering the topic of partner abuse in the workplace?	17 (85%)	18 (90%)	**18 (90%)**
	b) Does the Employee Assistance programme (or equivalent) maintain specific policies and procedures for dealing with employees experiencing partner abuse?	15 (75%)	16 (80%)	**16 (80%)**
	c) Is the topic of partner abuse among employees covered in the hospital training sessions and/or orientation?	20 (100%)	20 (100%)	**20 (100%)**
3.4	Does the hospital's partner abuse programme address cultural competency issues? If yes:			
	a) Does the hospital's policy specifically recommend universal screening regardless of the patient's cultural background?	20 (100%)	20 (100%)	**20 (100%)**
	b) Are cultural issues discussed in the hospital's partner abuse training programme?	19 (95%)	20 (100%)	**20 (100%)**
	c) Are translators/interpreters available for working with victims if English is not the victim's first language?	19 (95%)	20 (100%)	**20 (100%)**
	d) Are referral information and brochures related to partner abuse available in languages other than English?	20 (100%)	20 (100%)	**20 (100%)**
3.5	Does the hospital participate in preventive outreach and public education activities on the topic of partner abuse? If yes, is there documentation of: (*a or b and answer c*)	19 (95%)	19 (95%)	**19 (95%)**
	a) 1 programme in the last 12 months?	2 (10%)	3 (15%)	**1 (5%)**
	b) >1 programme in the last 12 months?	17 (85%)	16 (80%)	**19 (95%)**
	c) Does the hospital collaborate with Māori community organizations and providers to deliver preventive outreach and public education activities?	18 (90%)	16 (80%)	**19 (95%)**

	"YES" responses	108 mo FU DHBs (%)	120 mo FU DHBs (%)	2015 FU DHBs (%)
CATEGORY 4. TRAINING OF PROVIDERS				
4.1	Has a formal training plan been developed for the institution? If yes:	19 (95%)	20 (100%)	**19 (95%)**
	a) Does the plan include the provision of regular, ongoing education for clinical staff?	19 (95%)	20 (100%)	**20 (100%)**
	b) Does the plan include the provision of regular, ongoing education for non-clinical staff?	18 (90%)	17 (85%)	**18 (90%)**
4.2	During the past 12 months, has the hospital provided training on partner abuse:			
	a) as part of the mandatory orientation for new staff?	20 (100%)	19 (100%)	**20 (100%)**
	b) to members of the clinical staff via colloquia or other sessions?	20 (100%)	20 (100%)	**20 (100%)**
4.3	Does the hospital's training/education on partner abuse include information about:			
	a) definitions of partner abuse?	19 (95%)	20 (100%)	**20 (100%)**
	b) dynamics of partner abuse?	19 (95%)	20 (100%)	**20 (100%)**
	c) epidemiology?	19 (95%)	20 (100%)	**20 (100%)**
	d) health consequences?	20 (100%)	20 (100%)	**20 (100%)**
	e) strategies for screening?	20 (100%)	20 (100%)	**20 (100%)**
	f) risk assessment?	20 (100%)	20 (100%)	**20 (100%)**
	g) documentation?	19 (95%)	20 (100%)	**20 (100%)**
	h) intervention?	20 (100%)	20 (100%)	**20 (100%)**
	i) safety planning?	20 (100%)	20 (100%)	**20 (100%)**
	j) community resources?	20 (100%)	20 (100%)	**20 (100%)**
	k) reporting requirements?	19 (95%)	20 (100%)	**20 (100%)**
	l) legal issues?	20 (100%)	20 (100%)	**20 (100%)**
	m) confidentiality?	19 (95%)	20 (100%)	**20 (100%)**
	n) cultural competency?	19 (95%)	20 (100%)	**20 (100%)**
	o) clinical signs/symptoms?	19 (95%)	20 (100%)	**20 (100%)**
	p) Māori models of health?	19 (95%)	20 (100%)	**20 (100%)**
	q) risk assessment for children of victims?	20 (100%)	20 (100%)	**20 (100%)**
	r) social, cultural, historic, and economic context in which Māori family violence occurs?	19 (95%)	20 (100%)	18 (90%)
	s) te Tiriti o Waitangi?	19 (95%)	20 (100%)	**20 (100%)**
	t) Māori service providers and community resources?	19 (95%)	20 (100%)	**20 (100%)**
	u) service providers and community resources for ethnic and cultural groups other than Pakeha and Māori?	19 (95%)	20 (100%)	**20 (100%)**
	v) partner abuse in same-sex relationships?	18 (90%)	20 (100%)	**20 (100%)**
	w) service providers and community resources for victims of partner abuse who are in same-sex relationships?	18 (90%)	20 (100%)	**20 (100%)**

	"YES" responses	**108 mo FU DHBs (%)**	**120 mo FU DHBs (%)**	**2015 FU DHBs (%)**
4.4	Is the partner abuse training provided by: (*choose one a-c and answer d-e*)			
	a) a single individual?	1 (5%)	0 (0%)	**0 (0%)**
	b) a team of hospital employees only?	0 (0%)	0 (0%)	**0 (0%)**
	c) a team, including community expert(s)?	19 (95%)	20 (100%)	**20 (100%)**
	If provided by a team, does it include:			
	d) a Māori representative?	19 (95%)	19 (95%)	**19 (95%)**
	e) a representative(s) of other ethnic/cultural groups?	16 (80%)	14 (70%)	**15 (75%)**
CATEGORY 5. SCREENING AND SAFETY ASSESSMENT				
5.1	Does the hospital use a standardized instrument, with at least 3 questions, to screen patients for partner abuse? If	19 (95%)	20 (100%	**20 (100%)**
	a) included, as a separate form, in the clinical record?	0 (0%)	0 (0%)	**0 (0%)**
	b) incorporated as questions in the clinical record for all charts in ED or other out-patient area?	0 (0%)	0 (0%)	**0 (0%)**
	c) incorporated as questions in the clinical record for all charts in two or more out-patient areas?	7 (35%)	7 (35%)	**8 (40%)**
	d) incorporated as questions in clinical record for all charts in out-patient and in-patient areas?	12 (60%)	13 (65%)	**12 (60%)**
5.2	What percentage of eligible patients have documentation of partner abuse screening (based upon random sample of charts in any clinical area)?			
	Not done or not applicable	1 (5%)	0 (0%)	**1 (5%)**
	0% - 10%	4 (20%)	0 (0%)	**0 (0%)**
	11% - 25%	1 (5%)	2 ((10%)	**0 (0%)**
	26% - 50%	5 (25%)	8 (40%)	**5 (25%)**
	51% - 75%	5 (25%)	8 (40%)	**10 (50%)**
	76% - 100%	4 (20%)	2 (10%)	**4 (20%)**
5.3	Is a standardized safety assessment performed and discussed with victims who screen positive for partner abuse? If yes, does this:	18 (90%)	20 (100%)	**20 (100%)**
	a) also assess the safety of any children in the victim's care?	18 (90%)	20 (100%)	**20 (100%)**
CATEGORY 6. DOCUMENTATION				
6.1	Does the hospital use a standardized documentation instrument to record known or suspected cases of partner abuse? If yes, does the form include:	19 (95%)	20 (100%)	**20 (100%)**
	a) information on the results of partner abuse screening?	19 (95%)	20 (100%)	**20 (100%)**
	b) the victim's description of current and/or past abuse?	19 (95%)	19 (95%)	**20 (100%)**
	c) the name of the alleged perpetrator and relationship to the victim?	19 (95%)	20 (100%)	**20 (100%)**
	d) a body map to document injuries?	18 (90%)	19 (95%)	**19 (95%)**
	e) information documenting the referrals provided to the victim?	19 (95%)	20 (100%)	**20 (100%)**
	f) in the case of Māori, information documenting whether the individual was offered a Māori advocate?	19 (95%)	20 (100%)	**20 (100%)**

	"YES" responses	**108 mo FU DHBs (%)**	**120 mo FU DHBs (%)**	**2015 FU DHBs (%)**
6.2	Is forensic photography incorporated in the documentation procedure? If yes:			
	a) Is a fully operational camera with adequate film available in the treatment area?	19 (90%)	20 (100%)	**20 (100%)**
	b) Do hospital staff receive on-going training on the use of the camera?	13 (65%)	16 (80%)	**15 (75%)**
	c) Do hospital staff routinely offer to photograph all abused patients with injuries?	13 (65%)	16 (80%)	**13 (65%)**
	d) Is a specific, unique consent-to-photograph form obtained prior to photographing any injuries?	16 (80%)	15 (75%)	**15 (75%)**
	e) Do medical or nursing staff (not social work or a partner abuse advocate) photograph all injuries for medical documentation purposes, even if police obtain their own photographs for evidence purposes?	16 (80%)	16 (80%)	**17 (85%)**
CATEGORY 7. INTERVENTION SERVICES				
7.1	Is there a standard intervention checklist for staff to use/refer to when victims are identified?	19 (100%)	20 (100%)	**20 (100%)**
7.2	Are on-site victim advocacy services provided? If yes, *choose one a-b and answer c-d)*:	20 (100%	20 (100%)	**20 (100%)**
	a) A trained victim advocate provides services during certain hours.	2 (10%)	2 (10%)	**4 (20%)**
	b) A trained victim advocate provides service at all times.	18 (90%)	18 (95%	**16 (80%)**
	c) is a Māori advocate is available on-site for Māori victims?	20 (100%)	19 (100%)	**19 (95%)**
	d) is an advocate(s) of ethnic and cultural background other than Pakeha and Māori available onsite?	19 (95%)	18 (90%)	**18 (90%)**
7.3	Are mental health/psychological assessments performed within the context of the programme? If yes, are they:	20 (100%)	20 (100%)	
	a) available, when indicated?	8 (40%)	7 (35%)	**9 (45%)**
	b) performed routinely?	12 (60%)	13 (65%)	**11 (55%)**
7.4	Is transportation provided for victims, if needed?	20 (100%)	19 (95%)	**20 (100%)**
7.5	Does the hospital partner abuse programme include follow-up contact and counselling with victims after the initial assessment?	19 (95%)	18 (90%)	**20 (100%)**
7.6	Does the hospital partner abuse programme offer and provide on-site legal options counselling for victims?	20 (100%)	19 (95%)	**20 (100%)**
7.7	Does the hospital partner abuse programme offer and provide partner abuse services for the children of victims?	20 (100%)	20 (100%)	**20 (100%)**
7.8	Is there evidence of coordination between the hospital partner abuse programme and sexual assault, mental health and substance abuse screening and treatment?	20 (100%)	20 (100%)	**20 (100%)**
CATEGORY 8. EVALUATION ACTIVITIES				
8.1	Are any formal evaluation procedures in place to monitor the quality of the partner abuse programme? If yes:	19 (95%)	20 (100%)	**19 (95%)**
	a) Do evaluation activities include periodic monitoring of charts to audit for partner abuse screening?	18 (90%)	20 (100%)	**20 (100%)**
	b) Do evaluation activities include peer-to-peer case reviews around partner abuse?	18 (90%)	20 (100%)	**18 (90%)**
8.2	Do health care providers receive standardized feedback on their performance and on patients?	15 (75%)	18 (90%)	**19 (95%)**
8.3	Is there any measurement of client satisfaction and/or community satisfaction with the partner abuse programme?	16 (80%)	15 (75%)	**15 (75%)**
8.4	Is a quality framework (such as Whānau Ora) used to evaluate whether services are effective for Māori?	9 (45%)	10 (50%)	**11 (55%)**

	"YES" responses	108 mo FU DHBs (%)	120 mo FU DHBs (%)	2015 FU DHBs (%)
CATEGORY 9. COLLABORATION				
9.1	Does the hospital collaborate with local partner abuse programmes? If yes,	20 (100%)	20 (100%)	**20 (100%)**
	a i) collaboration with training?	19 (95%)	20 (100%)	**20 (100%)**
	ii) collaboration on policy and procedure development?	20 (100%)	20 (100%)	**20 (100%)**
	iii) collaboration on partner abuse working group?	19 (95%)	20 (100%)	**20 (100%)**
	iv) collaboration on site service provision?	20 (100%)	20 (100%)	**20 (100%)**
	b) is collaboration with			
	i) Māori provider(s) or representative(s)?	20 (100%)	20 (100%)	**20 (100%**
	ii) Provider(s) or representative(s) for ethnic or cultural groups other than Pakeha or Māori?	18 (90%)	19 (95%)	**18 (90%)**
9.2	Does the hospital collaborate with local police and courts in conjunction with their partner abuse programme? If yes:	20 (100%)	20 (100%	**20 (100%)**
	a) collaboration with training?	19 (95%)	20 (100%)	**20 (100%)**
	b) collaboration on policy and procedure development?	20 (100%)	20 (100%)	**20 (100%)**
	c) collaboration on partner abuse working group?	19 (95%)	20 (100%)	**20 (100%)**
9.3	Is there collaboration with the partner abuse programme of other health care facilities? If yes, which types of collaboration apply:	20 (100%)	20 (100%)	**20 (100%)**
	a) within the same health care system?	20 (100%)	20 (100%)	**20 (100%)**
	If yes, with a Māori health unit?	20 (100%)	19 (100%)	**18 (90%)**
	b) with other systems in the region?	20 (100%)	20 (100%)	**20 (100%)**
	If yes, with a Māori health provider?	19 (95%)	18 (90%)	**18 (90%)**

APPENDIX J. Child Abuse and Neglect Baseline and Follow-Up Scores

	Median										Achieving Target Score ≥ 70									≥80
	2004	***2005***	***2007***	***2008[a]***	***2009***	***2011***	***2012***	***2013***	***2014***	***2015***	***2004***	***2005***	***2007[b]***	***2008***	***2009***	***2011***	***2012***	***2013***	***2014***	***2015***
Overall Score	37	51	59	75	81	87	91	92	93	**93**	2 (8%)	3 (12%)	4 (15%)	17 (65%)	21 (78%)	25 (93%)	27 (100%)	19 95%)	20 (100%)	20 (100%)
Domain Scores																				
Policies and Procedures	43	50	60	81	84	92	95	95	96	**94**	3 (12%)	5 (20%)	8 (29%)	23 (89%)	19 (70%)	26 (96%)	27 (100%)	20 (100%)	20 (100%)	**20 (100%**
Safety and Security	-	-	-	77	72	82	90	92	96	**100**	-	-	-	17 (65%)	17 (63%)	23 (85%)	27 (100%)	19 (95%)	20 (100%)	**20 (100%)**
Collaboration	47	71	85	83	91	94	97	98	100	**100**	5 (20%)	15 (60%)	20 (74%)	21 (81%)	25 (93%)	26 (96%)	27 (100%)	20 (100%)	20 (100%)	**20 (100%)**
Institutional Culture	42	43	57	80	82	86	90	94	96	**96**	3 (12%)	5 20%	6 22%	18 69%	20 74%	25 93%	27 (100%)	20 (100%)	20 (100%)	**19 (95%)**
Training of Providers	40	49	67	93	96	98	100	100	100	**99**	2 (8%)	9 (36%)	14 (52%)	19 (73%)	22 (82%)	26 (96%)	27 (100%)	20 (100%)	20 (100%)	**20 (100%)**
Intervention Services	65	70	73	82	84	89	92	89	89	**91**	12 (48%)	13 (52%)	15 (56%)	21 (81%)	22 (82%)	27 (100%)	27 (100%)	20 (100%)	20 (100%)	**20 (100%)**
Documentation	19	29	58	84	83	87	93	96	97	**100**	5 (20%)	5 (20%)	8 (29%)	22 (85%)	19 70%)	22 (82%)	24 (89%)	19 (95%)	19 (95%)	**18 (90%)**
Evaluation Activities	35	37	37	30	59	72	76	73	80	**82**	1 (4%)	1 (4%)	5 (20%)	3 (12%)	7 (26%)	14 (52%)	18 (67%)	11 (55%)	15 (75%)	**13 (65%)**
Physical Environment	23	28	35.6	68	91	100	100	100	100	**91**	1 (4%)	2 (5%)	2 (7%)	12 (46%)	26 (96%)	27 (100%)	27 (100%)	19 (95%)	20 (100%)	**18 (18%)**

Notes: The unit of analysis changed from hospitals (n=27) to DHBs (n=20) for the 2013 follow-up audit: The selected benchmark score was raised from 70 to 80 for the 2015 follow-up audit.
The 2012 follow up scores include independent scores (n=13 hospitals) and self audit scores (n=14 hospitals). The 2013 and 2014 follow-up scores include self audit scores (n=16) and independent audit scores (n=4). The 2015 follow-up scores are all (n=20) from self audits. [a] Change to Revised Delphi tool; [b] 2007 follow-up percentages corrected;

APPENDIX K. Revised Child Abuse and Neglect Delphi Tool Item Analysis

Note: 96 month follow-up scores include independent scores (n=13 hospitals) and self audit scores (n=14 hospitals).

	"YES" responses	**108 mo FU DHBs (%)**	**120 mo FU DHBs (%)**	**2015 FU DHBs (%)**
CATEGORY 1. POLICIES AND PROCEDURES				
1.1	Are there official, written DHB policies regarding the clinical assessment, appropriate questioning, and treatment of suspected abused and neglected children? If so, do the policies:	20 (100%)	20 (100%)	**20 (100%)**
	a) Define child abuse and neglect?	20 (100%)	20 (100%)	**20 (100%)**
	b) Mandate training on child abuse and neglect for staff?	20 (100%)	20 (100%)	**20 (100%)**
	c) Outline age-appropriate protocols for risk assessment?	18 (90%)	19 (95%)	**19 (95%)**
	d) Define who is responsible for risk assessment?	19 (95%)	20 (100%)	**20 (100%**
	e) Address the issue of contamination during interviewing?	19 (95%)	20 (100%)	**20 (100%)**
	f) Address documentation?	19 (95%)	20 (100%)	**20 (100%)**
	g) Address referrals for children and their families?	19 (95%)	20 (100%)	**20 (100%)**
	h) Address child protection reporting requirements?	18 (90%)	20 (100%)	**20 (100%)**
	i) Address the responsibilities to, and needs of, Māori?	20 (100%)	20 (100%)	**20 (100%)**
	j) Address other cultural and/or ethnic groups?	20 (100%)	20 (100%)	**20 (100%)**
1.2	Who is consulted regarding child protection policies and procedures?			
	Māori and Pacific?	20 (100%)	20 (100%)	**20 (100%)**
	CYF?	19 (95%)	20 (100%)	**20 (100%)**
	Police?	18 (90%)	20 (100%)	**20 (100%)**
	Child abuse and neglect programme and Violence Intervention Programme staff?	20 (100%)	20 (100%)	**20 (100%)**
	Plus Other Agencies: such as Refuge; National Network of Stopping Violence Services (NNSVS); Office of the Children's Commissioner (OCC); Community Alcohol & Drug Service (CADS)	18 (90%)	19 (95%)	**20 (100%)**
1.3	Is there evidence of a DHB-based child abuse and neglect steering group? If yes, does the:			
	a) Steering group meet at least every three (3) months?	19 (95%)	19 (95%)	**15 (75%)**
	b) Include representatives from more than two departments?	19 (95%)	19 (95%)	**17 (85%)**

	"YES" responses	108 mo FU DHBs (%)	120 mo FU DHBs (%)	2015 FU DHBs (%)
1.4	Does the DHB provide direct financial support for the child abuse and neglect programme (beyond VIP funding)?	20 (100%)	20 (100%)	**20 (100%)**
	a) Is funding set aside specifically for Māori programmes and initiatives?	15 (75%)	11 (55%)	**13 (65%)**
1.5	Is there a policy for identifying signs and symptoms of child abuse and neglect and for identifying children at high risk? a) in both inpatient and outpatient areas?	20 (100%)	20 (100%)	**20 (100%)**
1.6	Are there procedures for security measures to be taken when suspected cases of child abuse and neglect are identified and the child is perceived to be at immediate risk? If yes, are the procedures:			
	a) written?	19 (95%)	20 (100%)	**20 (100%**
	b) include name/phone block?	16 (80%)	18 (90%)	**19 (95%)**
	c) provide for safe transportation?	16 (80%)	19 (95%)	**20 (100%)**
	d) account for the needs of Māori?	17 (85%)	19 (95%)	**19 (100%)**
1.7	Is there an identifiable child protection coordinator at the DHB? If yes, is the coordinator position (choose one):	20 (100%)	20 (100%)	**20 (100%)**
	a) part-time <0.5 FTE	2 (10%)	1 (5%)	**2 (10%)**
	b) part-time ≥0.5 FTE?	4 (20%)	6 (30%)	**7 (35%)**
	c) full-time?	14 (70%)	13 (65%)	**11 (55%)**
1.8	Are there policies that outline the minimum expectation for all staff:			
	a) to attend mandatory training?	20 (100%)	20 (100%)	**20 (20%)**
	b) to identification and referral children at risk?	20 (100%)	20 (100%)	**20 (100%)**
	c) to reporting child protection concerns?	19 (95%)	20 (100%)	**20 (100%)**
1.9	Do the child abuse and neglect policies and procedures indicate collaboration with government agencies and other relevant groups, such as the Police, CYF, refuge, and NNSVS ('men's programme provider')?			
	a) government agencies?	20 (100%)	20 (100%)	**20 (100%)**
	b) community groups?	20 (100%)	20 (100%)	**20 (100%)**
1.10	Are the DHB policies and procedures easily accessible and user-friendly? If yes, are	20 (100%)		
	a) they available on the DHB intranet?	20 (100%)	19 (95%)	**19 (95%)**
	b) there supporting and reference documents appended to the appropriate policies and procedures?	20 (100%)	20 (100%)	**18 (90%)**
	c) there translation materials to facilitate the application of policy and procedures, such as flowcharts and algorithms?	19 (95%)	20 (100%)	**19 (95%)**
1.11	Are the DHB policies and procedures cross-referenced to other forms of family violence, such as partner abuse and elder abuse?	20 (100%)	20 (100%)	**20 (100%)**

	"YES" responses	**108 mo FU DHBs (%)**	**120 mo FU DHBs (%)**	2015 FU DHBs (%)
CATEGORY 2. SAFETY & SECURITY				
2.1	Does the DHB have a policy in place that all children are assessed when signs and symptoms are suggestive of abuse and/or neglect?	20 (100%)	20 (100%)	**20 (100%)**
2.2	Does the DHB have a protocol for collaborative safety planning for children at high risk?			
	a) are safety plans available or used for children identified at risk? Which types of collaboration apply:	19 (95%)	19 (95%)	**20 (100%)**
	b) within the DHB?	20 (100%)	20 (100%)	**20 (100%)**
	c) with other groups and agencies in the region?	19 (95%)	20 (100%)	**20 (100%)**
	d) with Māori and Pacific health providers?	20 (100%)	20 (100%)	**20 (100%)**
	e) with other relevant ethnic/cultural groups?	17 (85%)	18 (90%)	**19 (95%)**
	f) with the primary health sector?	19 (95%)	18 (90%)	**20 (100%)**
2.3	Does the DHB have a protocol to promote the safety of children identified at risk of abuse or neglect?			
	a) within the DHB?	20 (100%)	20 (100%)	**20 (100%)**
	b) with relevant primary health care providers as part of discharge planning?	19 (95%)	20 (100%)	**20 (100%)**
	c) by accessing necessary support services for the child and family to promote ongoing safety of the child?	20 (100%)	20 (100%)	**20 (100%)**
2.4	Do inpatient facilities have a security plan where people at risk of perpetrating abuse, or who have a protection order against them, can be denied entry?	19 (95%)	20 (100%)	**20 (100%)**
2.5	Do the DHB services have an alert system or a central database recording any concerns about children at risk of abuse and neglect in place?			
	b) a local alert system in acute care setting	19 (95%)	18 (90%)	**19 (95%)**
	c) a local alert system in community setting, including PHO	9 (45%)	15 (75%)	**15 (75%)**
	d) a process for notification of alert placements to relevant providers	14 (70%)	18 (90%)	**18 (90%)**
	e) participation in a national alert system (108 Mo. note 8 NCPAS approved + 3 self-reporting that in process)	11 (55%)	15 (75%)	**18 (90%)**
	f) clear criteria for identifying levels of risk, and process that guides the use of the alert system	13 (65%)	17 (85%)	**19 (95%)**
2.6	Is there evidence in protocols of processes to assess or refer to CYF and/or other appropriate agencies all children living in the house when child abuse and neglect or partner violence has been identified?			
	a) process that includes the safety of other children in the home are considered?	19 (95%)	20 (100%)	**20 (100%)**
	b) process for notifying CYF and/or other agencies?	19 (95%)	20 (100%)	**20 (100%)**
	c) referral form that requires the documentation of the risk assessed for these children?	18 (90%)	20 (100%)	**20 (100%)**

	"YES" responses	108 mo FU DHBs (%)	120 mo FU DHBs (%)	2015 FU DHBs (%)
	CATEGORY 3. COLLABORATION			
3.1	Does the DHB collaborate with CYF and NGO child advocacy and protection?	20 (100%)	20 (100%)	**20 (100%)**
	a) which types of collaboration apply:			
	i) collaboration with training?	20 (100%)	20 (100%)	**20 (100%)**
	ii) collaboration on policy and procedure development?	20 (100%)	20 (100%)	**20 (100%)**
	iii) collaboration on child abuse and neglect task force?	19 (95%)	20 (100%)	**20 (100%)**
	iv) collaboration on site service provision?	19 (95%)	20 (100%)	**20 (100%)**
	v) collaboration is two-way?	20 (100%)	20 (100%)	**20 (100%)**
	b) is collaboration with:			
	i) CYF?	20 (100%)	20 (100%)	**20 (100%)**
	ii) NGOs and other agencies such as Women's Refuge?	20 (100%)	20 (100%)	**19 (95%)**
	iii) Māori provider(s) or representative(s)?	20 (100%)	20 (100%)	**20 (100%)**
	iv) Provider(s) or representative(s) for ethnic or cultural groups other than Pakeha or Māori?	18 (90%)	18 (90%)	**19 (95%)**
	c) services, departments and between relevant staff within the DHB evident?	20 (100%)	20 (100%)	**20 (100%)**
3.2	Does the DHB collaborate with police and prosecution agencies in conjunction with their child abuse and neglect programme? If yes, which types of collaboration apply:	20 (100%)	20 (100%)	**20 (100%)**
	a) collaboration with training?	20 (100%)	20 (100%)	**20 (100%)**
	b) collaboration on policy and procedure development?	20 (100%)	20 (100%)	**20 (100%)**
	c) collaboration on child abuse and neglect task force?	19 (95%)	19 (95%)	**18 (90%)**
3.3	Is there collaboration of the child abuse and neglect programme with other health care facilities? If yes, which types of collaboration apply:	20 (100%)	20 (100%)	**20 (100%)**
	a) within the DHB?	20 (100%)	20 (100%)	**20 (100%)**
	b) with a Māori unit?	20 (100%)	20 (100%)	**20 (100%)**
	c) with other groups and agencies in the region?	20 (100%)	20 (100%)	**20 (100%)**
	d) with a Māori health provider?	19 (95%)	20 (100%)	**20 (100%)**
	e) with the primary health care sector?	20 (100%)	19 (95%)	**19 (95%)**
	f) with national network of child protection and family violence coordinators?	20 (100%)	20 (100%)	**20 (100%)**

	"YES" responses	108 mo FU DHBs (%)	120 mo FU DHBs (%)	2015 FU DHBs (%)
3.4	Do relevant staff have membership on, or attend:			
	a) the interdisciplinary child protection team?	20 (100%)	20 (100%)	**20 (100%)**
	b) Child abuse team meetings?	20 (100%)	20 (100%)	**19 (95%)**
	c) Sexual abuse team meetings?	18 (90%)	17 (85%)	**16 (80%)**
	d) CYF Care and Protection Resource Panel?	17 (85%)	18 (90%)	**15 (75%)**
	e) National Network of Family Violence Intervention Coordinators?	20 (100%)	20 (100%)	**19 (95%)**
3.5	Does the DHB have a Memorandum of Understanding that enables the sharing of details of children at risk for entry on their database with the Police and/or CYF?			
	a) CYF?	20 (100%)	20 (100%)	**20 (100%)**
	b) the Police?	20 (100%)	20 (100%)	**20 (100%)**
3.6	Does the DHB have a Memorandum of Understanding or service agreement that enables timely medical examinations to support:			
	a) CYF?	18 (90%)	19 (95%)	**20 (100%)**
	b) Police?	18 (90%)	19 (95%)	**20 (100%)**
	c) DSAC?	17 (85%)	17 (85%)	**18 (90%)**
CATEGORY 4. INSTITUTIONAL CULTURE				
4.1	Does the DHB senior management support and promote the child abuse and neglect programme?			
	a) child protection is in the DHB Strategic Plan?	15 (75%)	18 (90%)	**19 (95%)**
	b) child protection is in the DHB Annual Plan?	16 (80%)	20 (100%)	**20 (100%)**
	c) the child protection programme is adequately resourced, including dedicated programme staff?	16 (80%)	18 (90%)	**18 (90%)**
	d) a working group of skilled and trained people who operationalises policies and procedures, in addition to the child protection coordinator?	20 (100%)	20 (100%)	**20 (100%)**
	e) attendance at training as a key performance indicator (KPI) for staff?	13 (65%)	13 (65%)	**15 (75%)**
	f) roles of those in the child abuse and neglect working team are included in position descriptions?	15 (75%)	18 (90%)	**18 (90%)**
	g) DHB representation on the CYF Care and Protection Resource Panel?	17 (85%)	19 (95%)	**17 (85%)**
	h) the Child Protection Coordinator is supported to attend the VIP Coordinator Meetings?	20 (100%)	20 (100%)	**19 (95%)**

	"YES" responses	**108 mo FU DHBs (%)**	**120 mo FU DHBs (%)**	**2015 FU DHBs (%)**
4.2	In the last 3 years, has there been a formal (written) assessment of the DHB staff's knowledge and attitude about child abuse and neglect?	20 (100%	19 (95%)	**17 (85%)**
	a) nursing staff	20 (100%)	19 (95%)	**17 (85%)**
	b) medical staff	18 (90%)	16 (80%)	**14 (70%)**
	c) administration	15 (75%)	14 (70%)	**12 (60%)**
	d) other staff/employees	18 (90%)	19 (95%)	**17 (85%)**
	If yes, did the assessment address staff knowledge and attitude about Māori and child abuse and neglect?	17 (85%)	19 (95%)	**16 (80%)**
4.3	How long has the hospital's child abuse and neglect programme been in existence?			
	a) 24-48 months			
	b) >48 months	20 (100%)	20 (100%)	**20 (100%)**
4.4	Does the DHB's child abuse and neglect programme address cultural issues?			
	a) does the DHBs policies specifically require implementation of the child abuse and neglect clinical assessment policy regardless of the child's cultural background?	20 (100%)	20 (100%)	**20 (100%)**
	b) does the child protection coordinator and the steering group work with the Māori health unit and other cultural/ethnic groups relevant to the DHBs demographics?	20 (100%)	20 (100%)	**19 (95%)**
	c) Are cultural issues discussed in the hospital's child abuse and neglect training programme?	20 (100%)	20 (100%)	**20 (100%)**
	d) are translators/interpreters available for working with victims if English is not the victim's first language?	20 (100%)	20 (100%)	**20 (100%)**
	e) Are referral information and brochures related to child abuse and neglect available in languages other than English?	16 (80%)	17 (85%)	**19 (95%)**
4.5	Does the DHB participate in prevention outreach/public education activities on the topic of child abuse and neglect?	20 (100%)	20 (100%)	**19 (95%)**
	a) 1 programme in the last 12 months?	2 (10%)	3 (15%)	**3 (15%)**
	b) >1 programme in the last 12 months?	18 (90%)	17 (85%)	**16 (80%)**
	c) Does the DHB collaborate with Māori community organisations and providers to deliver preventive outreach and public education activities?	17 (85%)	18 (90%)	**19 (95%)**
4.6	Do policies and procedures indicate the availability of supportive interventions for staff who have experienced abuse and neglect, or who are perpetrators of abuse and neglect?	20 (100%)	19 (95%)	**20 (100%)**
	a) is a list of supportive interventions available?	20 (100%)	20 (100%)	**20 (100%)**
	b) are staff aware of how to access support and interventions available?	20 (100%)	20 (100%)	**20 (100%)**

	"YES" responses	**108 mo FU DHBs (%)**	**120 mo FU DHBs (%)**	**2015 FU DHBs (%)**
4.7	Is there evidence of coordination between the DHB child abuse and neglect programme in collaboration with other violence intervention programmes?	19 (95%)	20 (100%)	**20 (100**
	a) is there is a referral mechanism?	20 (100%)	20 (100%)	**19 (100%)**
4.8	Does the child protection policy require mandatory use of DHB approved translators when English is not the victim's or caregiver's first language?			
	a) DHB approved translators being used?	20 (100%)	20 (100%)	**20 (100%)**
	b) a list of translators is accessible?	20 (100%)	20 (100%)	**20 (100%)**
	c) translators used that are gender and age appropriate?	15 (75%)	16 (80%)	**16 (80%)**
4.9	Does the DHB support and promote child protection and intervention within the primary sector.			
	a) involvement of primary health care providers in the planning and development of child abuse and neglect and child protection programmes?	20 (100%)	18 (90%)	**19 (95%)**
	b) access to child abuse and neglect training?	19 (95%)	19 (95%)	**20 (100%)**
	c) coordination of referral processes between the DHB and primary health care sectors?	17 (85%)	18 (90%)	**19 (95%)**
	d) ongoing relationships and activities that focus on prevention and promoting child protection?	20 (100%)	19 (95%)	**20 (100%)**
CATEGORY 5. TRAINING OF PROVIDERS				
5.1	Is there evidence of a formal training plan that is specific to child abuse and neglect for clinical staff and non-clinical staff?			
	a) a strategic plan for training?	19 (95%)	20 (100%)	**20 (100%)**
	b) an operational plan that outlines the specifics of the programme of training?	19 (95%)	20 (100%)	**20 (100%)**
	c) Does the plan include the provision of regular, ongoing education for clinical staff?	19 (95%)	20 (100%)	**20 (100%)**
	d) Does the plan include the provision of regular, ongoing education for non-clinical staff?	19 (95%)	20 (100%)	**20 (100%)**
5.2	During the past 12 months, has the DHB provided training on child abuse and neglect?			
	a) as part of the mandatory orientation for new staff?	19 (95%)	19 (95%)	**20 (100%)**
	b) to members of the clinical staff via colloquia or other sessions?	20 (100%)	20 (100%)	**20 (100%)**
5.3	Does the training/education on child abuse and neglect include information about:			
	a) definitions of child abuse and neglect?	20 (100%)	20 (100%)	**20 (100%)**
	b) dynamics of child abuse and neglect?	20 (100%)	20 (100%)	**20 (100%)**
	c) child advocacy?	20 (100%)	20 (100%)	**20 (100%)**
	d) appropriate child-centred interviewing?	20 (100%)	20 (100%)	**20 (100%)**
	e) issues of contamination?	20 (100%)	20 (100%)	**19 (95%)**
	f) ethical dilemmas?	20 (100%)	20 (100%)	**20 (100%)**

	"YES" responses	**108 mo FU DHBs (%)**	**120 mo FU DHBs (%)**	**2015 FU DHBs (%)**
	g) conflict of interest?	20 (100%)	20 (100%)	**20 (100%)**
	h) epidemiology?	20 (100%)	20 (100%)	**20 (100%)**
	i) health consequences?	20 (100%)	20 (100%)	**20 (100%)**
	j) identifying high risk indicators?	20 (100%)	20 (100%)	**20 (100%)**
	k) physical signs and symptoms?	20 (100%)	20 (100%)	**20 (100%)**
	l) dual assessment with partner violence?	19 (100%)	20 (100%)	**20 (100%)**
	m) documentation?	20 (100%)	20 (100%)	**20 (100%)**
	n) intervention?	20 (100%)	20 (100%)	**20 (100%)**
	o) safety planning?	20 (100%)	20 (100%)	**20 (100%)**
	p) community resources?	20 (100%)	20 (100%)	**20 (100%)**
	q) child protection reporting requirements?	20 (100%)	20 (100%)	**20 (100%)**
	r) linking with the police and child youth and family?	20 (100%)	20 (100%)	**20 (100%)**
	s) limits of confidentiality?	20 (100%)	20 (100%)	**20 (100%)**
	t) age appropriate assessment and intervention?	19 (95%)	20 (100%)	**20 (100%)**
	u) cultural issues?	20 (100%)	20 (100%)	**20 (100%)**
	v) link between partner violence and child abuse and neglect?	20 (100%)	20 (100%)	**20 (100%)**
	w) Māori models of health?	19 (95%))	19 (95%)	**19 (95%)**
	x) the social, cultural, historic, and economic context in which Māori family violence occurs?	18 (90%)	19 (95%)	**20 (100%)**
	y) Te Tiriti o Waitangi?	20 (100%)	20 (100%)	**20 (100%)**
	z) Māori service providers and community resources?	20 (100%)	20 (100%)	**20 (100%)**
	aa) service providers and community resources for ethic and cultural groups other than Pakeha and Māori?	19 (100%)	18 (90%)	**19 (95%)**
	ab) If all sub-items are evident, bonus 1.5	16 (80%)	18 (90%)	**19 (95%)**
5.4	Is the child abuse and neglect training provided by: (*choose one of a-d and answer e-f)*			
	c) a team of DHB employees only?	1 (5%)	0 (0%)	**1 (5%)**
	d) a team, including community expert(s)?	19 (95%)	20 (100%)	**19 (95%)**
	e) a Child Youth and Family statutory social worker?	19 (95%)	20 (100%)	**20 (100%)**
	f) a Māori representative?	19 (95%)	18 (90%)	**18 (90%)**
	g) a representative(s) of other ethnic/cultural groups?	13 (65%)	12 (60%)	**12 (60%)**

	"YES" responses	**108 mo FU DHBs (%)**	**120 mo FU DHBs (%)**	**2015 FU DHBs (%)**
5.5	Is the training delivered in collaboration with various disciplines, and providers of child protection services, such as CYF, Police and community agencies?	20 (100%)	20 (100%)	**20 (100%)**
5.6	Does the plan include a range of teaching and learning approaches used to deliver training on child abuse and neglect?	20 (100%)	20 (100%)	**20 (100%)**
CATEGORY 6. INTERVENTION SERVICES				
6.1	Is there a standard intervention checklist for staff to use/refer to when suspected cases of child abuse and neglect are identified?	20 (100%)	20 (100%)	**20 (100%)**
6.2	Are child protection services available "on-site"? If yes, *choose one of a-b and answer c-d*:	20 (100%)		
	a) A member of the child protection team or social worker provides services during certain hours.	5 (25%)	8 (40%)	**5 (25%)**
	b) A member of the child protection team or social worker provides service at all times.	15 (75%)	12 (60%)	**15 (75%)**
	c) A Māori advocate or social worker is available "on-site" for Māori victims.	19 (95%)	19 (95%)	**19 (95%)**
	d) An advocate of ethnic and cultural background other Pakeha and Māori is available onsite.	16 (80%)	15 (75%)	**15 (75%)**
6.3	Are mental health/psychological assessments performed within the context of the programme? If yes, are they: (*choose a or b and answer c*)	20 (100%)	20 (100%)	
	a) available, when indicated?	12 (60%)	11 (55%)	**13 (65%)**
	b) performed routinely?	8 (40%)	9 (45%)	**7 (35%)**
	c) age-appropriate?	20 (100%)	20 (100%)	**20 (100%)**
6.4	Do the intervention services include:			
	a) access to physical and sexual examination?	20 (100%)	20 (100%)	**20 (100%)**
	b) access to specialised sexual abuse services?	20 (100%)	20 (100%)	**20 (100%)**
	c) family focused interventions?	19 (100%)	20 (100%)	**19 (95%)**
	d) support services that include relevant NGOs, or acute crisis counsellors/support?	19 (95%)	20 (100%)	**20 (100%)**
	e) culturally appropriate advocacy and support?	19 (95%)	20 (100%)	**20 (100%)**
6.5	Are Social Workers available?			
	a) Monday to Friday 8 am to 4 pm service, with referrals outside of these hours?	12 (60%)	11 (55%)	**10 (50%)**
	b) 0n-call after 4 pm and at weekends?	3 (15%)	2 (10%)	**4 (20%)**
	c) as a 24 hour service?	5 (25%)	7 (35%)	**6 (30%)**
6.6	Is there a current list of relevant services available to support child and family safety?	20 (100%)	20 (100%)	**20 (100%)**
6.7	Is provision made for transport for victims and their families, if needed?	20 (100%)	20 (100%)	**20 (100%)**
6.8	Does the DHB child abuse and neglect programme include follow-up contact and counselling with victims after the initial assessment?	20 (100%)	20 (100%)	**20 (100%)**

	"YES" responses	108 mo FU DHBs (%)	120 mo FU DHBs (%)	2015 FU DHBs (%)
6.9	Does the child abuse and neglect programme assess and provide family violence intervention services and appropriate referral for:			
	a) the mother	20 (100%)	20 (100%)	**20 (100%)**
	b) siblings	19 (95%)	20 (100%)	**20 (100%)**
6.10	Is there evidence of coordination with CYF and the Police for children identified at risk of child abuse and neglect?	20 (100%)	20 (100%)	**20 (100%)**
CATEGORY 7. DOCUMENTATION				
7.1	Is there evidence of use of a standardised documentation form to record known or suspected cases of child abuse and neglect, and safety assessments? If yes, does the form include:		20 (100%)	**20 (100%)**
	a) Reason for presentation?	19 (95%)	20 (100%)	**20 (100%)**
	b) information generated by risk assessment?	18 (90%)	19 (95%)	**19 (95%)**
	c) the victim or caregiver's description of current and/or past abuse?	19 (95%)	20 (100%)	**20 (100%)**
	d) the name of the alleged perpetrator and relationship to the victim?	16 (80%)	18 (90%)	**19 (95%)**
	e) a body map to document injuries?	19 (95%)	20 (100%)	**20 (100%)**
	f) Past medical history?	18 (90%)	20 (100%)	**20 (100%)**
	g) A social history, including living circumstances?	18 (90%)	20 (100%)	**20 (100%)**
	h) An injury assessment, including photographic evidence (if appropriate)?	17 (85%)	20 (100%)	**20 (100%)**
	i) The interventions undertaken?	18 (90%)	19 (95%)	**20 (100%)**
	j) information documenting the referrals provided to the victim and their family?	19 (95%)	20 (100%)	**20 (100%)**
	k) in the case of Māori, information documenting whether the victim and their family were offered a Māori advocate?	14 (70%)	16 (80%)	**18 (90%)**
7.2	Does the DHB have sexual abuse specific forms that include:			
	a) a genital diagram?	19 (95%)	18 (90%)	**16 (80%)**
	b) a consent form?	17 (85%)	17 (85%)	**17 (85%)**
7.3	Is there evidence of use of a standardised referral form and process for CYF and/or Police notification? If yes, is a referral form and process available for:	20 (100%)		
	a) CYF notification?	20 (100%)	20 (100%)	**20 (100%)**
	b) Police notification?	15 (75%)	14 (70%)	**14 (70%)**
7.4	Are staff provided training on documentation for children regarding abuse and neglect?	20 (100%)	20 (100%)	**20 (100%)**

	"YES" responses	**108 mo FU DHBs (%)**	**120 mo FU DHBs (%)**	2015 FU DHBs (%)
CATEGORY 8. EVALUATION ACTIVITIES				
8.1	Are any formal evaluation procedures in place to monitor the quality of the child abuse and neglect programme? If yes:			
	a) Do evaluation activities include periodic monitoring of implementation of child abuse and neglect clinical assessment policy?	20 (100%)	20 (100%)	**19 (95%)**
	b) Is the evaluation process standardised?	17 (85%)	17 (85%)	**17 (85%)**
	c) Do evaluation activities measure outcomes, either for entire programme or components thereof?	18 (90%)	19 (95%)	**18 (90%)**
	d) Does the evaluation of the programme include relevant review/audit of the following activities:			
	Identification, risk assessment, admissions and referral activities?	18 (90%)	18 (90%)	**17 (85%)**
	Monitoring trends re demographics, risk factors, and types of abuse?	15 (75%)	15 (75%)	**15 (75%)**
	Documentation?	17 (85%)	18 (90%)	**17 (85%)**
	Referrals to CYF and the Police?	18 (90%)	19 (95%)	**18 (90%)**
	Case reviews?	17 (85%)	17 (85%)	**19 (95%)**
	Critical incidents?	19 (95%)	18 (90%)	**19 (95%)**
	Mortality morbidity review?	19 (95%)	18 (90%)	**17 (85%)**
	Policy and procedure reviews?	20 (100%)	19 (95%)	**20 (100%)**
	e) Do the evaluation activities include:			
	Multidisciplinary team members?	20 (100%)	20 (100%)	**20 (100%)**
	Police?	19 (95%)	18 (90%)	**17 (85%)**
	CYF?	19 (95%)	20 (100%)	**20 (100%)**
	Community agencies?	19 (95%)	17 (85%)	**16 (80%)**
8.2	Is there evidence of feedback on the child abuse and neglect programme from community agencies and government services providers, such as CYF, the Police, refuge, and well child providers?	16 (80%)	18 (90%)	**17 (85%)**
8.3	Do health care providers receive standardized feedback on their performance and on patients from CYF?	14 (70%)	14 (70%)	**14 (70%)**
8.4	Is there any measurement of client satisfaction and community satisfaction with the child abuse and neglect programme?			
	a) client satisfaction?	10 (50%)	6 (30%)	**8 (40%)**
	b) community satisfaction?	14 (70%)	18 (90%)	**17 (85%)**

	"YES" responses	108 mo FU DHBs (%)	120 mo FU DHBs (%)	2015 FU DHBs (%)
8.5	Is a quality framework used to evaluate whether services are effective for Māori?	9 (45%)	8 (40%)	**8 (40%)**
8.6	Are data related to child abuse and neglect assessments, identifications, referrals and alert status recorded, collated and reported on to the DHB?	14 (70%)	18 (90%)	**16 (80%)**
8.7	Is the child abuse and neglect programme evident in the DHB quality and risk programme?	19 (95%)	17 (85%)	**19 (95%)**
8.8	Is the responsibility for acting on evaluation recommendations specified in the policies and procedures?	11 (55%)	14 (70%)	**17 (85%)**
CATEGORY 9. PHYSICAL ENVIRONMENT				
9.1	How many locations with posters/images relevant to children and young people which are they child-friendly, contain messages about child rights and safety, and contain Māori and other relevant cultural or ethnic images?			
	a) <10 posters or images	1 (5%)	0 (0%)	**0 (0%)**
	b) 10-20 posters or images	3 (15%)	3 (15%)	**2 (10%)**
	c) >20 posters or images	16 (80%)	17 (85%)	**16 (80%)**
9.2	Is there referral information (local or national phone numbers) related to child advocacy and relevant services on public display in the DHB? (Can be included on the posters/brochure noted above).			
	a) <10 locations	1 (5%)	1 (5%)	**1 (5%)**
	b) 10-20 locations	4 (20%)	4 (20%)	**4 (20%)**
	c) >20 locations	15 (75%)	15 (75%)	**15 (75%)**
9.3	Are there designated private spaces available for interviewing?			
	a) > 4 locations?	20 (100%)	20 (100%)	**19 (100%)**
9.4	Does the DHB provide temporary (<24 hours) safe shelter for victims of child abuse and neglect and their families who cannot go home or cannot be placed in a community-based shelter until CYF or a refuge intervene?			
	a) 'Social admissions" mentioned in child abuse and neglect policies?	17 (85%)	18 (90%)	**17 (85%)**
	b) Temporary safe shelter is available?	18 (90%)	19 (95%)	**19 (95%)**