HOSPITAL RESPONSIVENESS TO FAMILY VIOLENCE:

120 MONTH FOLLOW-UP EVALUATION

CENTRE FOR INTERDISCIPLINARY TRAUMA RESEARCH
AUT UNIVERSITY

MINISTRY OF HEALTH
MANATŪ HAUORA

VIP violence intervention programme

AUT

HEALTH RESPONSE TO FAMILY VIOLENCE: 2014 VIOLENCE INTERVENTION PROGRAMME EVALUATION REPORT

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EXECUTIVE SUMMARY

The Ministry of Health (MOH) **Violence Intervention Programme** (VIP) seeks to reduce and prevent the health impacts of 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.

This report documents nationwide results of the inaugural Snapshot audit of VIP implementation in three selected services along with results of the Delphi Audit of VIP System indicators. This report provides Government, the Ministry and DHBs with information and accountability data on family violence intervention programme implementation. VIP contributes towards the NZ Government's Delivering Better Public Services, Supporting Vulnerable Children Result Action Plan[1], and the Ministry's Statement of Intent 2014 to 2018.[2]

VIP SNAPSHOT AUDITS

VIP Snapshot audits were introduced into the VIP Evaluation Programme for the first time in 2014. They indicate a shift in the national VIP evaluation focus from DHB infrastructure development to accountability and performance improvements[3] in the delivery of services for vulnerable children and their whānau and families. The Snapshot audits used a standardised reporting process implemented by DHBs nationwide allowing pooling of data to estimate (1) VIP output – women and children assessed for violence and abuse – as well as (2) VIP outcomes – women and children with a violence concern who received specialist assistance.

Three DHB services were selected: Partner Abuse (PA) clinical audits in Postnatal Maternity Inpatient and Child Health Inpatient Services, and Child Abuse and Neglect (CAN) clinical audits in the Emergency Departments (ED) for children aged under two years presenting for any reason. The Snapshot audits involved retrospective reviews of a random selection of clinical records from 1 April to 30 June (second quarter) 2014. This Snapshot delivers the baseline data against which future VIP Snapshot audits will be compared.

The 2014 Snapshot data evidences that nationally:

- For approximately one of every four (27%) children under two years presenting to an emergency department, their clinical assessment includes a child protection screen.
- For approximately one of every three (39%) children admitted to child health inpatient services, their female caregiver is assessed for partner abuse.
- Approximately one in every three (33%) women admitted to postnatal maternity services are assessed for partner abuse.

Figure 1 presents national estimates for the number of women admitted in designated services from 1 April to 30 June 2014 who (1) were assessed for partner abuse, (2) disclosed partner abuse and (3) received a specialist family violence service referral (either onsite or offsite). Figure 2 presents national estimates for the number of children under the age of two years seen in an Emergency Department from 1 April to 30 June 2014 and who (1) were assessed for child abuse and neglect, (2) had a child protection concern identified and (3) for which there was a specialist consultation related to the child protection concern.

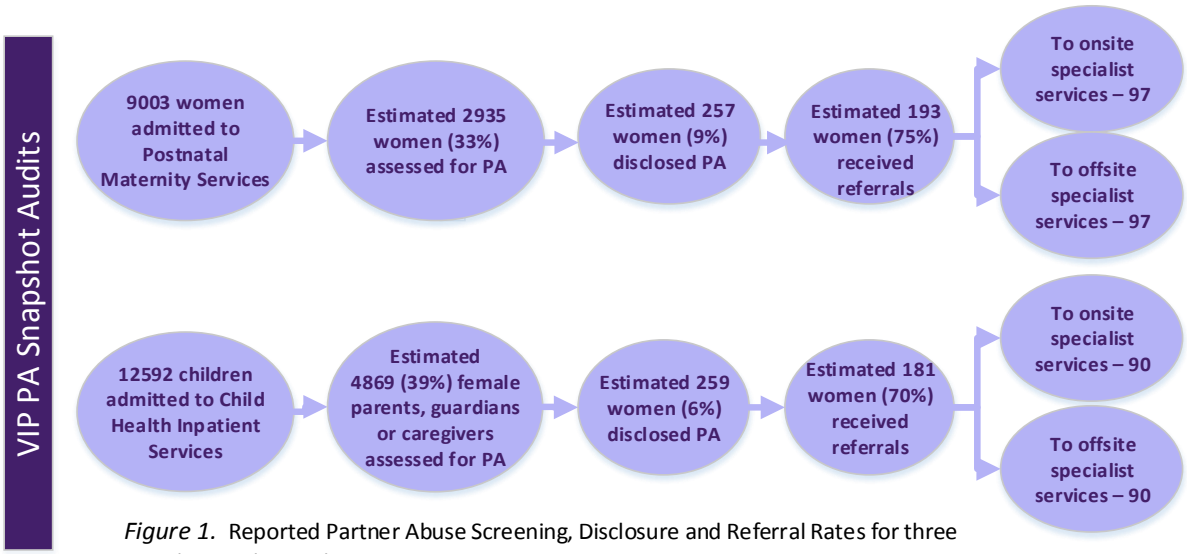


Figure 1. Reported Partner Abuse Screening, Disclosure and Referral Rates for three month period 1 April to 30 June 2015.

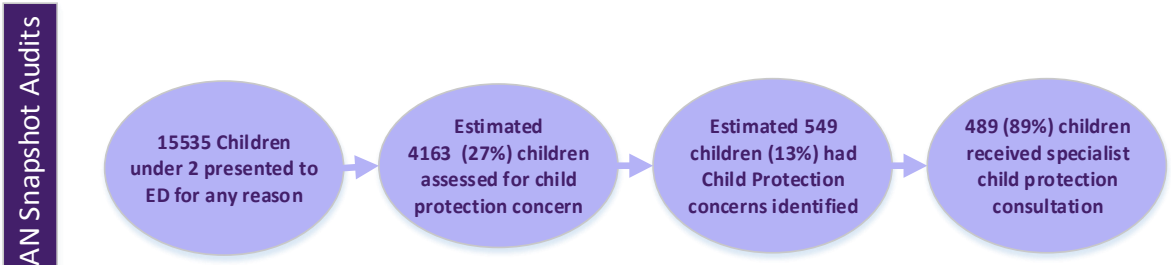


Figure 2. Reported Child Abuse and Neglect Risk Assessment, Concern and Consultation Rates for three month period 1 April to 30 June 2015.

VIP INFRASTRUCTURE DELPHI AUDIT

This report also documents the result of measuring system indicators at 20 DHBs. Based on programme maturity, 16 DHBs completed a self audit for the 2014 follow-up audit; the remaining 4 were independently audited (including site visits). All data are based on the combined self audit and independent audit scores for 2014. The median DHB score was 92 (possible range 0 to 100) for partner abuse and 93 for child abuse and neglect programmes (Figure 3). Data evidenced that with current resources, system elements have been consistently maintained over three years.

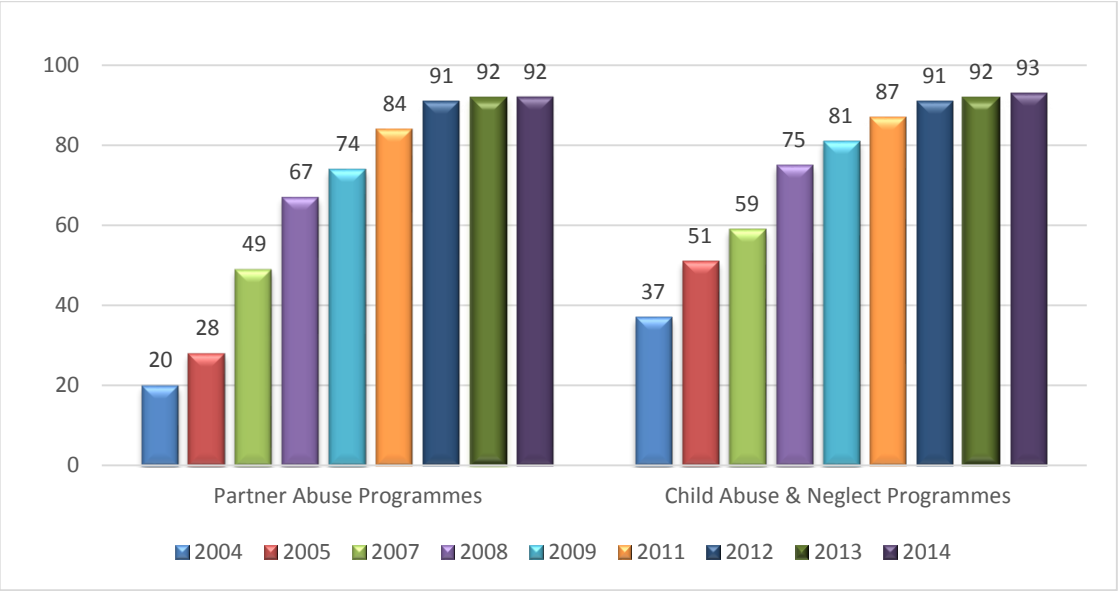


Figure 3. Median Violence Intervention Programme (VIP) Scores (2004-2014)

VIP Scores > 80 were achieved by 100% of DHBs in the CAN Intervention Programme; and by 95% of DHBs (n=19) in the PA Intervention Programme

- All 20 DHBs had a dedicated Family Violence Intervention (FVI) Coordinator in place at the time of the audit. However, turnover of FVI Coordinators (including Child Protection Coordinators), their managers and VIP clinical champions, and the subsequent periods of vacancies and induction, pose a risk for VIP sustainability.
- All 20 DHBs had been approved to deliver the Ministry-approved standardised national VIP training package, with wide variation in the proportion of staff that have been trained across professions and services.
- Internal audit processes monitoring policy implementation quality remain variable across DHBs.

VIP recognises culturally responsive health systems contribute to reducing health inequalities. The overall DHB VIP cultural responsiveness score for partner abuse was 93 (95 in 2013) and for child abuse and neglect programmes the score was 91 (91 in 2013). While these median scores reflect the infrastructure required to support culturally responsive practice, only 50% (n=10) of DHBs evaluated whether their services were effective for Māori in the VIP Partner Abuse Programme and 40% (n=8) in the VIP Child Abuse and Neglect Programme. Eighty-five per cent (n=17) of DHB VIP strategic plans identified actions to improve cultural responsiveness to Māori and to contribute to Whānau Ora workforce development.

DHBs are doing well overall and are working towards making contributions to the government policies to reduce violence against children and women. However, there are still improvements needed to deliver a consistent, quality service nationwide.

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.[4-12] Early identification of people subjected to violence followed by a supportive and effective response can improve safety and wellbeing.[13] 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.[14,15,16]

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 Government's Taskforce for Action on Violence within Families.[17] The Violence Intervention Programme is strategically aligned with the Children's Action Plan, 2012[18] Vulnerable Children's Act 2014[19],' and government priority to reduce the number of physical assaults on children (Better Public Services Key Result Action Area, 2013).[1] 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".[1] This target is based on Child, Youth and Family 'substantiated' cases of physical abuse. For the Violence Intervention Programme, 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 are two outputs of interest. Of note, the National Child Protection Alert System will also have a monitoring and evaluation process specified.

VIP in DHBs is premised on a standardised, comprehensive systems approach[20,21] supported by six programme components funded by the Ministry (Figure 4). These components include:

- District Health Board Family Violence Intervention Coordinators (FVIC).
- Ministry of Health Family Violence Intervention Guidelines: Child and Partner Abuse (2002, 2015).
- 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.

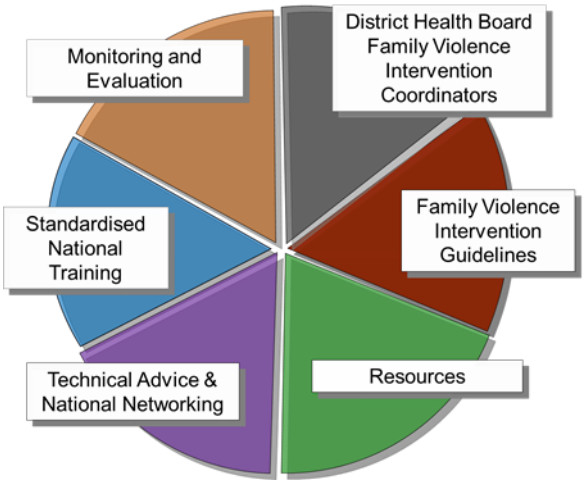


Figure 4. Ministry of Health VIP Systems Support Model (DHBs)

This report documents the results of three evaluation work streams. **Firstly**, DHB programme inputs (system infrastructure) were assessed against criteria for an ideal programme using the Delphi tools (see pp. 8-10). 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 such as programme funding, development of the VIP Quality Improvement Toolkit, Model for Improvement workshops and a Whānau-Centred resource[22]. **Secondly**, programme implementation was assessed collating and analysing DHB submitted information regarding programme strategic planning, work force capacity (training), internal audit findings and rollout across services. **Thirdly**, programme outputs were assessed implementing a nationally standardised clinical Snapshot audit. Snapshot audits conducted in New South Wales have proved useful in monitoring service delivery.[23,24] The New Zealand 2014 Snapshot measured VIP implementation in three selected services. This inaugural Snapshot provides accountability data and a baseline for monitoring the effect of future system changes on service delivery to vulnerable children and their families and whānau nationally.

This evaluation provides practice-based evidence of the current violence intervention programme inputs, outputs and outcomes (Figure 5). 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 (Children's Action Plan,[18] The Vulnerable Children's Act 2014[19], and Better Public Services Targets[1]) and Whānau Ora.[22]

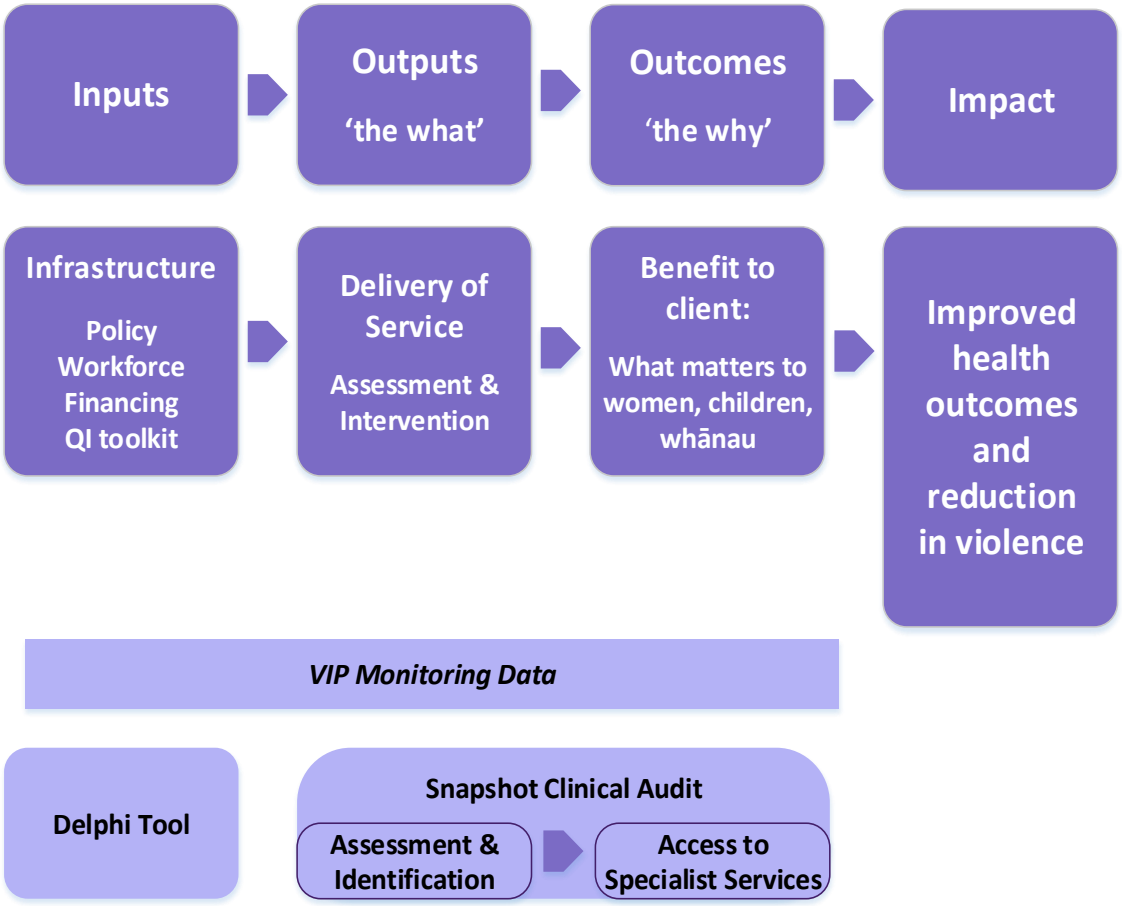


Figure 5: VIP Evaluation Monitoring Data Sources

This evaluation sought to answer the following questions:

1. How are New Zealand District Health Boards performing in terms of institutional support for family violence prevention?
2. Is institutional change sustained over time?
3. What is the rate of programme service delivery across DHBs?
4. How many women and children are estimated to have received VIP assessment and intervention?

METHODS

Participation in the evaluation process was specified in Ministry 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 5/12/15).

Evaluation procedures were conducted based on a philosophy of supporting programme leaders in building a culture of improvement.[25,26] Details of the 2014 evaluation processes are outlined in Figure 6 and Appendix C and D. The process began on 13 June 2014 with a letter from the Ministry advising DHBs of the upcoming 2014 audit round.

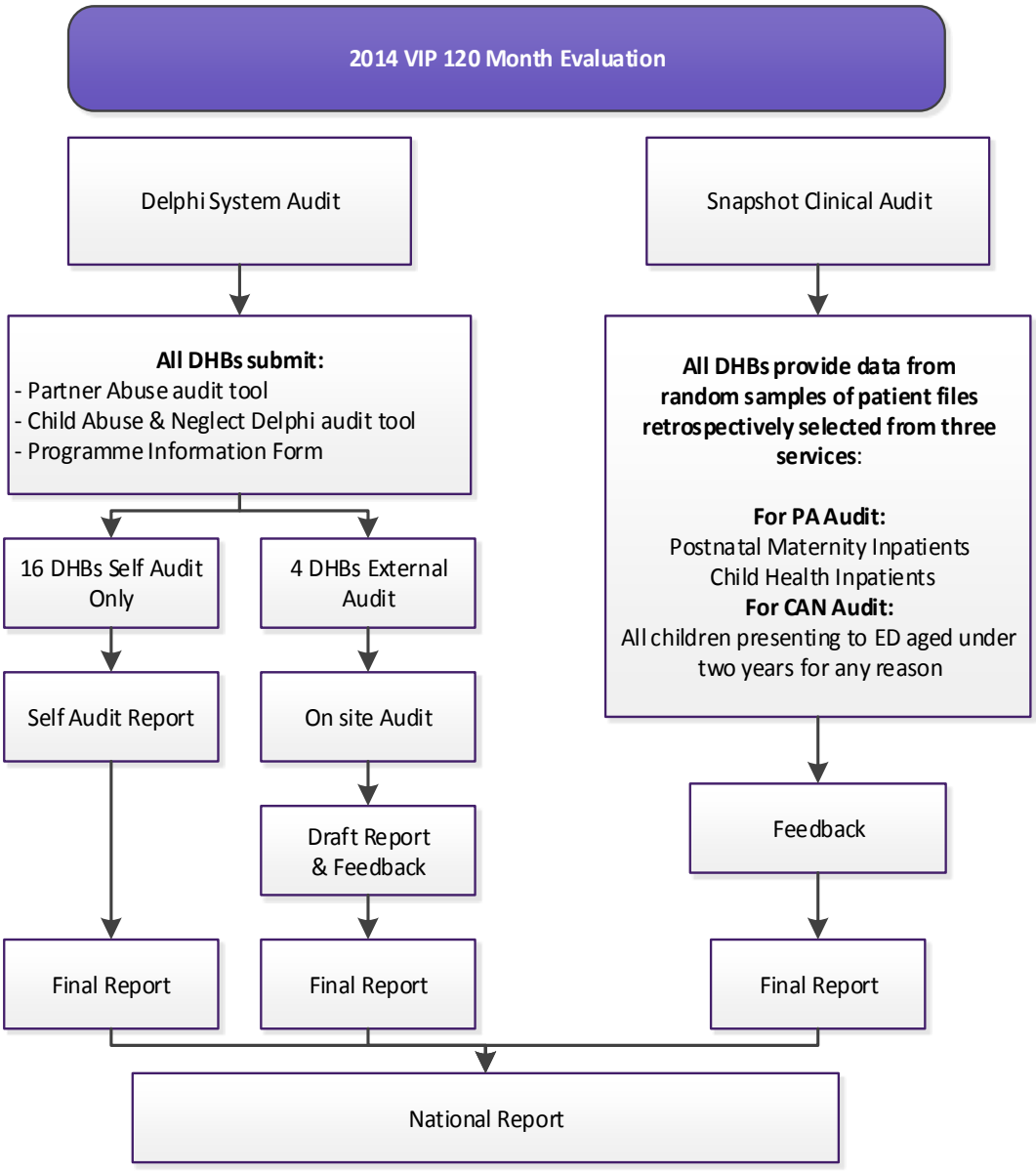
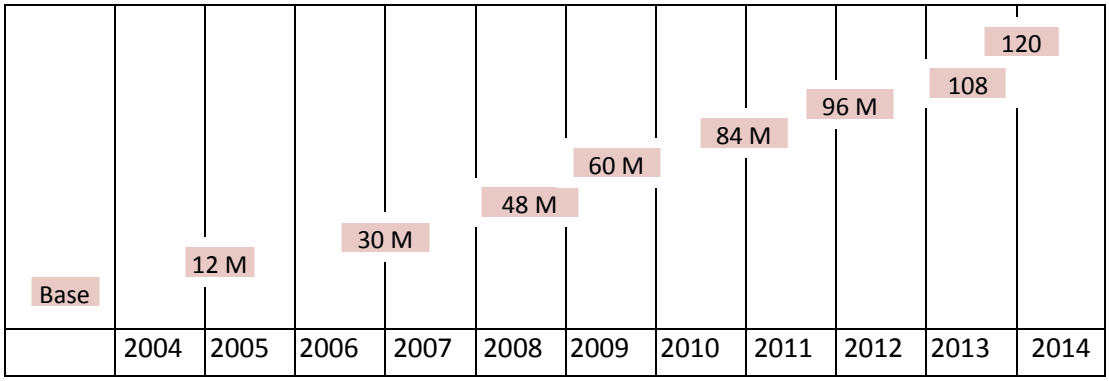


Figure 6. 120 Month (2014) Evaluation Plan

SYSTEM INFRASTRUCTURE (DELPHI TOOL) METHODS

DHBs were invited to submit self audit data between April and September 2014, for the audit period 1 July 2013 to 30 June 2014. The 2014 audit was the ninth audit measuring system development (Figure 7). 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 2014 (including identification of their programme achievements, strengths, areas for improvements, and an improvement action plan).



Note: M=months from baseline.

Figure 7. Audit Round Time Periods

PA & CAN Programme Evaluation Audit Tools

Quantitative independent and 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 Programmes*[27-29] 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.[30,31] This *Revised CAN Tool* has been used since the 48 month follow-up audit. The audit tools are available (open access at www.aut.ac.nz/vipevaluation) as interactive Excel files. This format allows 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 categorised into nine domains (see Table 2). The *Screening and Safety Assessment* domain is unique to the PA tool; the *Safety and Security* domain is unique to the CAN tool. The domains reflect components consistent with a systems model approach.[13,20,21,32,33] 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 scheme where some domains are weighted higher than others (see Appendix D for domain weights).

Table 1. Audit Tool Domains

Policies and Procedures	•policies and procedures outline assessment and treatment of victims; mandate identification and training; and direct sustainability
Safety and Security	•children and young people are assessed for safety, safety risks are identified and security plans implemented [CAN tool only]
Physical Environment	•posters and brochures let patients and vistors 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 and 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

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) and Child Abuse and Neglect (n=28) audit tools. These items contribute to a cultural responsiveness score, standardised to range from 0 to 100.[34]

Procedure

In addition to self-audit, independent audit site visits were conducted in 2014 at 4 DHBs (Capital & Coast, Lakes, Southern and Waitemata). The 4 DHBs were independently audited as they were considered to be undergoing significant system change by the VIP Management Group. Shortly after DHB notification by the Ministry in June 2014, independent audit staff contacted VIP managers and Family Violence Intervention Coordinators (FVIC) by e-mail to outline whether they were scheduled for self audit only (n=16), or self audit followed by independent audit (n=4). A confirmatory e-mail identified site visit dates for DHBs scheduled for an independent audit. Where an independent audit was conducted, debriefing meetings were attended by DHB VIP leaders such as the senior management VIP sponsor, FVIC, audit participants, and steering group members to discuss programme highlights and challenges alongside preliminary audit results.

Reporting

Where independent audits were conducted, a draft report was provided to the DHB VIP portfolio manager or designee. The report included a summary outlining DHB programme progress, strengths and recommendations for improvement, independent audit scores and an indicator table of achievements and suggested improvements. Self audit scores were also noted within the report. VIP managers were asked to involve relevant others (e.g., DHB FVI coordinators, steering group members) in the review process and confirm the accuracy of the draft audit report and provide feedback. Once confirmed, the finalised report was sent to the DHB Chief Executive, copied to the DHB VIP portfolio manager, FVI Coordinator(s) and the Ministry.

Documentation received from both self audit DHBs (n=16) and independent audit DHBs (n=4) were reviewed by the independent evaluation team. Modifications to the submitted self audit reports were made to correct errors and enhance readability. Brief independent auditor comments were added; comments typically addressed programme scores, service delivery status, and the self audit report. The modified self audit report was then sent to the DHB CEO copied to the DHB VIP portfolio manager, FVI Coordinator(s) and the Ministry.

Analysis

Self and Independent audit data were exported from Excel audit tools into an SPSS Statistics (Version 22) file. Score calculations were confirmed between Excel and SPSS files. Data from the VIP Evaluation Self Audit Report: 120 month (2014) follow up form (Appendix C) were also entered into an SPSS file. Analyses were conducted in SPSS.

The 2014 audit scores represent independent audit scores for the 4 DHBs that had an independent evaluation and self audit scores for the remaining 16 DHBs.

120 month follow up results combine self audit scores for 16 DHBs and independent audit scores for 4 DHBs.

In this report we present baseline, 12, 30, 48, 60, 84, 96, 108 and 120 month follow up (2014) domain and overall Delphi scores. 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 DHB. The unit of analysis in baseline to 96 month follow up was hospital. The change to analysis by DHB was implemented due to a lack of 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 METHODS

VIP programme information is collected as part of the DHB self audit process. It allows DHBs to summarise their programme progress since the previous audit and identify programme strengths and challenges. The Self Audit Report (Appendix D) also includes information about the proportion of staff who have completed VIP core training, Whānau Ora initiatives and a summary of internal clinical audit findings. This information is generally included in DHBs twice yearly reporting to the Ministry. Programme information assists the national VIP management team to monitor programme implementation.

SNAPSHOT METHODS

The Snapshot audit aims to collect "accountability data that matter to external parties"[35] and provide baseline data for local and national quality improvement activities. In early 2014 the VIP National Team and a quality improvement specialist considered the following issues in planning the Snapshot:

- Time period for retrospective random sampling of cases (over one or three months)
- Selection criteria, definition, and prioritising of targeted services
- Collection of ethnicity data
- Child protection assessment (screen) eligibility (all children or children with injuries; upper age limit)
- The number of essential indicators to include, recognising the trade-off between keeping the Snapshot simple and feasible and having a better understanding of the quality of service delivery
- DHBs are to continue using the VIP Quality Improvement Toolkit for in depth analysis and monitoring the effect of programme changes.

The Snapshot plan was presented at the National Network of Violence Intervention Programme Coordinators (NNVIPC) meeting in Wellington in April 2014. Using workshop techniques, meeting participants achieved consensus on Snapshot criteria and processes.

Previous audits, in line with the 2002 MOH Guidelines[7] and the VIP Quality Improvement Toolkit, have focused on clinical audit of children presenting to the emergency department with an injury (Child Injury Flowchart audit). The change in focus to all children under the age of two presenting for any reason was in response to current best practice evidence[36-39] and aligned to the upcoming revised MOH Guidelines.

A simple secure, web-based pilot IT system was developed for DHBs to input the Snapshot clinical audit data. All data were entered de-identified (no individual/unique identifiers were collected). Data entry was pilot tested in November 2014. All DHBs were subsequently requested to submit their Snapshot data before the end of December 2014. The final contributing DHB entered their data by the 1st April 2015.

The 2014 Snapshot was considered a starting point to test the process, to allow DHBs to learn the process and to ensure feasibility. The goal was to ensure a standardised rigorous review. Instructions provided to DHBs for the inaugural VIP Snapshot audit are outlined in Appendix C.

Service Selection

Three services (from among the six MOH targeted services) were selected for the inaugural VIP Snapshot audit as they addressed a critical child development period and were consistent with current government initiatives to prevent child injury. Together they involve the delivery of both partner abuse and child abuse and neglect assessment and intervention services.

These services included:

Partner Abuse Clinical Audit

- **Postnatal Maternity** Hospital Admissions
- **Child Health** Hospital Admissions (Female guardians, parents or care givers assessed for partner abuse)

Child Abuse & Neglect Clinical Audit

- **Emergency Department** (ED) children under two years of age for any reason

Sampling Scheme and Eligibility

Within each DHB, for each service, a random sample of eligible records during the three month audit period (**1 April – 30 June 2014**) were retrospectively reviewed by DHB VIP staff or delegates. DHBs were to sample only main sites (e.g., secondary or tertiary hospitals). Twenty-five records were reviewed at each DHB for postnatal maternity and ED services; and fifty records for child health (as there may not be an identifiable female guardian or caregiver noted in the record). Therefore, the Snapshot involved each DHB reviewing a total of 100 clinical records.

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
- **Emergency Department** - all children under the age of two years presenting to Emergency Services 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 (New Zealand European, New Zealand Māori, Samoan, Cook Island Māori, Tongan, Nuiean, Chinese, Indian, and Other).
- Child's Age (ranging between 0 – 16 years) for Child Health inpatient service only.
- Partner Abuse variables:
    - PA screen (yes or no)
    - PA disclosure (yes or no)
    - PA referral (onsite, offsite or none)
- Child Abuse and Neglect variables:
    - CAN assessment (yes or no)
    - CAN concern identified (yes or no)
    - CAN consultation (yes or no)

NZ Census 2013 Ethnicity data definitions include all people who state their ethnic group, whether as their only ethnic group or as one of several ethnic groups. Where a person reported more than one ethnic group, they are counted in each applicable group. The same principle has been applied in reporting ethnicity of children and women randomly selected and screened / assessed in the VIP Snapshot audits 2014.

Analysis

Snapshot data were exported from the secure web-based server in a .csv file and imported into SPSS Statistics (Version 22). Descriptive analysis included for PA: number of eligible women screened, screening rate (%), number who disclosed, disclosure rate (%), number who received off-site and on-site referrals and the referral rate (%). CAN data included the number of eligible children assessed, child protection assessment rate (%), number of children with child protection concerns, CAN concern rate (%), the number of consultations and consultation rate (%). Individual Snapshot results were provided to the DHB Portfolio Manager, copied to the Line Manager, FVI Coordinator and the Ministry in February/March 2015.

From data submitted by each DHB for each service, a national mean screening rate was derived from individual DHB screening rates weighted by the number of clients seen per DHB during the period. Data was 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.

FINDINGS: INFRASTRUCTURE

PARTNER ABUSE PROGRAMME

In 2014, Partner Abuse intervention programme scores > 80 were achieved by 95% of DHBs (n=19).

The following system indicator data is based on combining self audit (16 DHBs) and independent audit (4 DHBs) scores. Indicators have remained constant to facilitate monitoring change over time. The Ministry's minimal achievement threshold (target score) of 70 was set in 2004 based on international and New Zealand baseline data. Since then, as demonstrated in Figure 8, partner abuse programme scores have increased substantially over time and 100% of DHBs have achieved the Ministry's 2004 target. In 2014, 19 DHBs (95%) achieved a score > 80; the Ministry has identified 80 as the minimum score for programme maintenance. Appendix I provides supporting data for the Figures and Tables in this section.

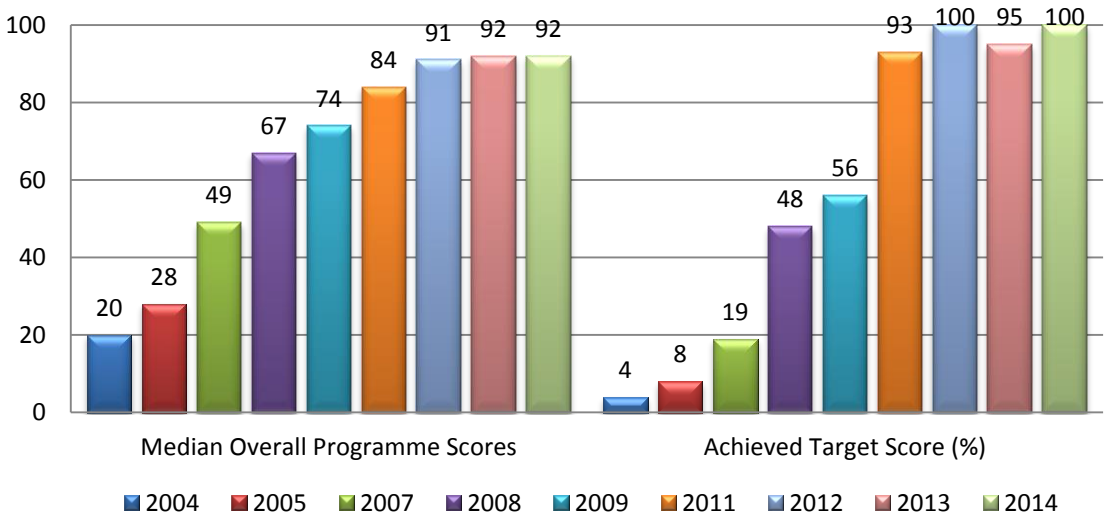


Figure 8. Partner Abuse Violence Intervention Programme Scores 2004-2014

Variability in scores over time is shown in Figure 9. At baseline, scores were consistently (SD=18.1) at the lower range of the scale, with a single high scoring outlier. This was followed by a period of wide score variation peaking at the 30 month follow up audit (SD=26.2), indicating a period of change. Since the 84 month follow up audit, scores were again consistent, but at the higher range of the scale. The partner abuse score standard deviation in 2014 was 5.6.

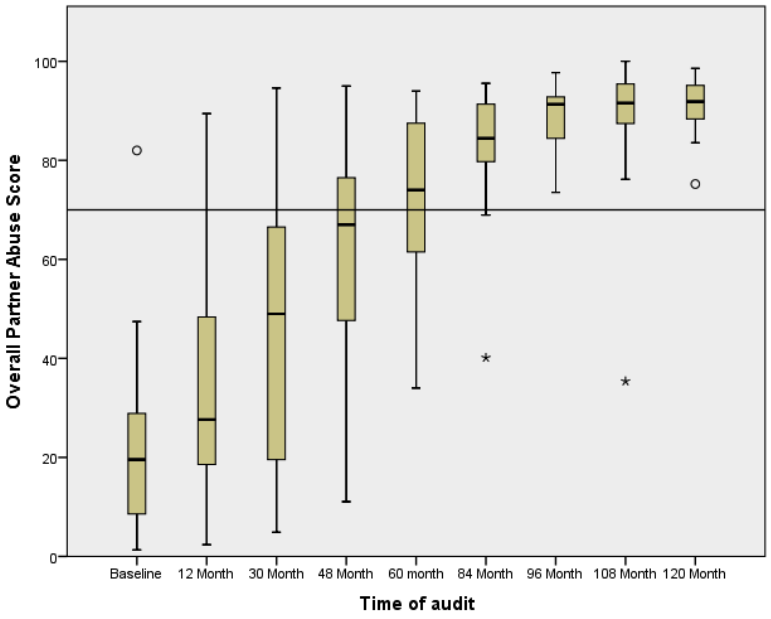


Figure 9. Overall partner abuse score distributions over time.

Partner Abuse Programme Indicators

Many indicators of a systems approach for responding to partner abuse are now 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 H.

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.

100% (20) of DHBs have a formal partner abuse response training plan; 95% (19) of DHBs have agreements with regional refuge services or similar to support health professional training.

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.

90% (n=18) of DHBs have conducted quality improvement activities since the last audit.

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

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.

90% (n=18) of DHBs include information on partner abuse in same-sex relationships in training along with information on service providers and community resources.

Partner Abuse Programme Domains[a]

All nine partner abuse programme domain median scores exceeded the target score of 70 (Figure 12). Between the 2013 and 2014 audits, median *Documentation* and *Evaluation Activities* domain scores both increased by 10 (90 to 100 and 80 to 90 respectively). *Screening and Safety Assessment* (median=87), *Policies & Procedures* (median=87) and *Evaluation Activities* (median=90) are the domains that have potential for further development in 2015.

Partner Abuse Programme League Tables

The DHB league table for the 2014 partner abuse intervention programme scores is presented in Table 2. The amount of change since the last audit (absolute score difference) ranged from a decrease of 15 to an increase of 24.

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 2. 2014 Follow-Up Partner Abuse DHB League Table

Rank			Target (70%)	Change from 2013
1	Bay of Plenty (S)	99		0
2	Waikato (S)	98		3
3	Counties Manukau (S)	98		2
4	Northland (S)	96		1
5	MidCentral (S)	95		0
6	Southern	95		3
7	Canterbury (S)	93		2
8	Waitemata	93		-6
9	Lakes	92		24
10	Tairawhiti (S)	92		-1
11	Taranaki (S)	92		4
12	Wairarapa (S)	91		-4
13	West Coast (S)	90		1
14	South Canterbury (S)	90		-2
15	Whanganui (S)	89		10
16	Auckland (S)	88		0
17	Hutt Valley (S)	87		-1
18	Hawke's Bay (S)	85		-15
19	Nelson Marlborough (S)	84		4
20	Capital & Coast	75		-1
	DHB Median	**92**		0

Table Notes: (S) Self Audit

[a] Tool domains are described in Table 1, page 9.

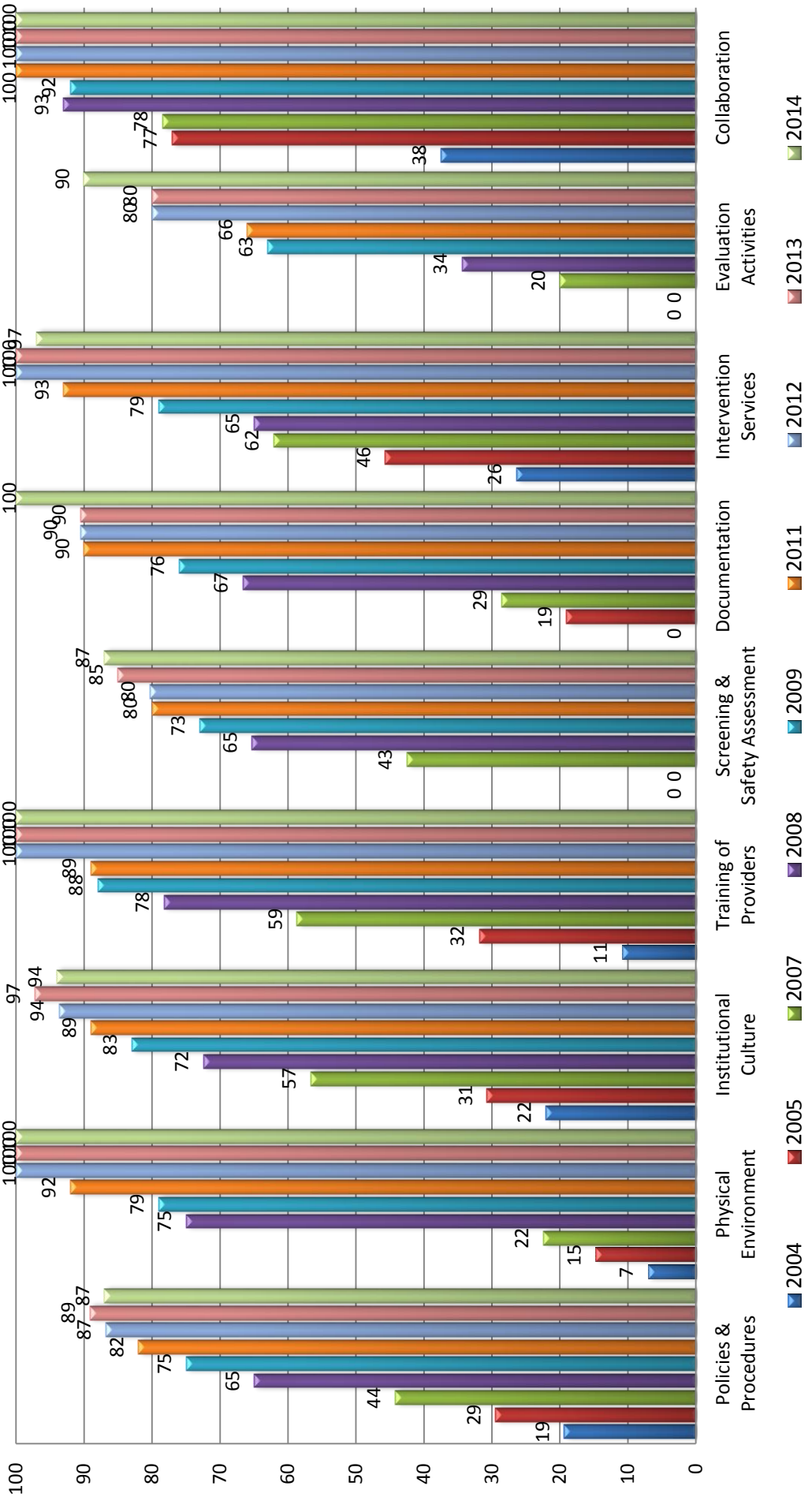


Figure 10. Partner Abuse Violence Intervention Programme Domain Median Scores

CHILD ABUSE AND NEGLECT PROGRAMMES

Child abuse and neglect (CAN) programme scores have increased significantly over time (Figure 11). With programme maturity, a median score above 90 has been maintained for three audit periods. Appendix J provides the data supporting the Figures and Tables in this section.

In 2014, Child Abuse and Neglect intervention programme scores greater than 80 were achieved by all DHBs (n=20).

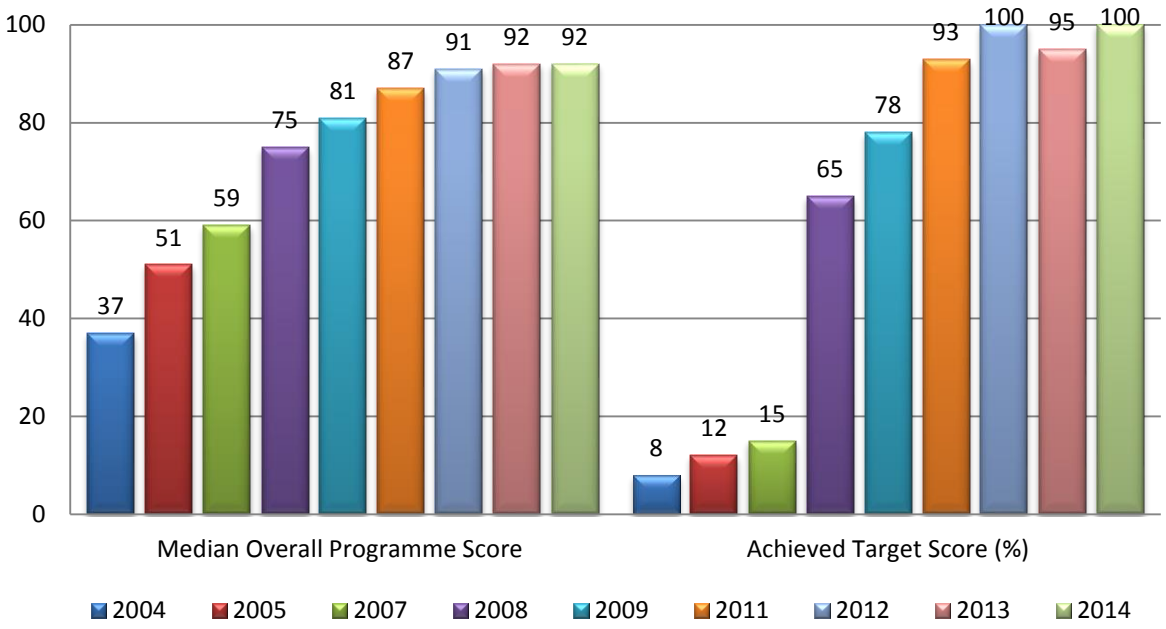


Figure 11. Child Abuse and Neglect Programme Scores (2004-2014)

Accompanying higher scores over time has been less score variation (Figure 12). The maximum score variation for CAN programmes was at baseline (SD=19.4), reducing appreciably over time. The standard deviation for 2014 CAN programme scores was 4.1 (with no outliers).

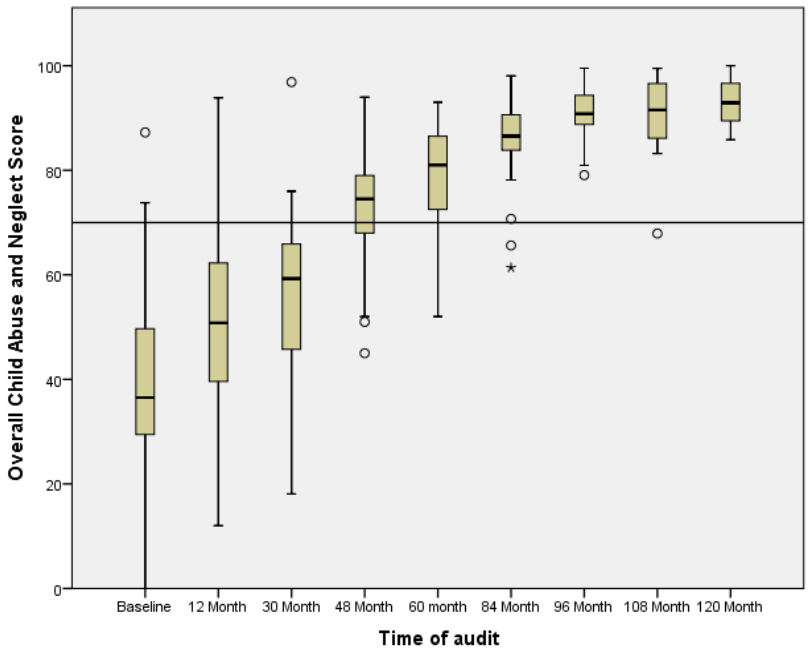


Figure 12. DHB Overall Child Abuse and Neglect Score Distributions over Time.

DHBs have achieved significant infrastructure to support a systems approach for responding to child abuse and neglect. Multi-Disciplinary Team (MDT) processes are improving over time as working relationships internal and external to health systems are developed. The Memorandum of Understanding between Child, Youth and Family, New Zealand Police and District Health Boards outlines agency responsibilities, and Schedule 2 references the Child, Youth and Family DHB Liaison Social Worker resource.[41] Health and safety for children are likely to improve as DHBs continue to implement the Memorandum of Understanding and the National Child Protection Alert System.[42] The Maternity Care Wellbeing and Child Protection Multiagency Group has also prepared a toolkit to facilitate multi-agency work to strengthen vulnerable families during the maternity period.

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 individual child abuse and neglect programme tool 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 child abuse and neglect programmes collaborate with Child, Youth and Family and the Police in programme planning and safety planning for children at risk.

85% (n=17) of DHBs include their child abuse and neglect programme in their DHB Quality and Risk programme.

DHBs are collaborating with primary health care providers in addressing vulnerable children:
All (n=20) DHBs include primary health care providers in discharge planning;
90% (n=18) of DHBs coordinate referral processes for care transitions between secondary and primary care.

90% (n=18) of DHBs record, collate and report on data related to child abuse and neglect assessments, identifications, referrals and alert status to senior management;
75% (n=15) of DHBs monitor demographics, risk factors and types of abuse trends.

75% (n=15) of DHBs had approved National Child Protection Alert Systems (NCPAS); 25% (n=5) were working to join NCPAS.

Child Abuse & Neglect Programme Domains[a]

All nine child abuse and neglect programme domain median scores exceeded the target score of 70 (Figure 13). Between the 2013 and 2014 audits, the median *Evaluation Activities* domain score increased by 7 (73 to 80), though it remains the domain with the most potential for further development in 2015.

Child Abuse and Neglect Programme League Tables

The DHB league table for the 2014 child abuse and neglect intervention programme scores is presented in Table 3. The amount of change since the last audit (absolute score difference) ranged from a decrease of 14 to an increase of 25.

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 some 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 3. 2014 Child Abuse and Neglect DHB League Table

Rank			Target (70%)	Change from 2013
1	Bay of Plenty (S)	100		4
2	Waitemata	99		0
3	Counties Manukau (S)	99		0
4	Auckland (S)	98		-1
5	Canterbury (S)	97		3
6	Northland (S)	96		10
7	MidCentral (S)	95		2
8	Waikato (S)	94		2
9	South Canterbury (S)	94		-1
10	Wairarapa (S)	93		-4
11	Lakes	93		25
12	Taranaki (S)	92		1
13	Tairawhiti (S)	92		-1
14	Nelson Marlborough (S)	90		7
15	Whanganui (S)	90		4
16	Southern	89		-3
17	Hutt Valley (S)	88		2
18	West Coast (S)	88		4
19	Capital & Coast	88		1
20	Hawkes Bay (S)	86		-14
	DHB Median	**93**		1

[a] Tool domains are described in Table 1 (page 9).

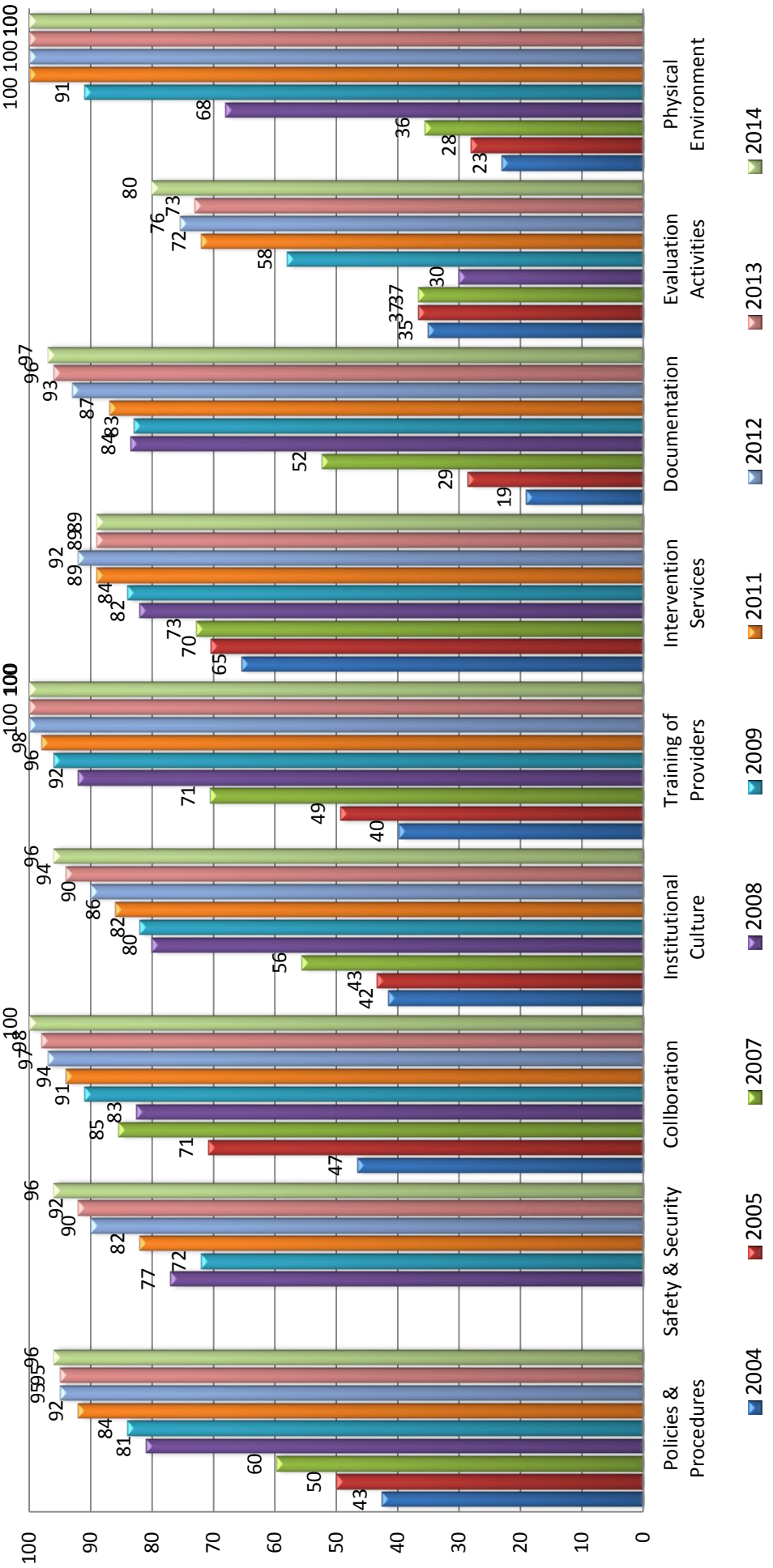


Figure 13. Child Abuse and Neglect Programme Domain Median Scores

Note. The revised Child Abuse and Neglect audit tool, with the new Safety & Security domain, was implemented beginning 2008 follow-up audit.

CULTURAL RESPONSIVENESS AND WHĀNAU ORA

VIP recognises culturally responsive health systems contribute to reducing health inequalities. The following Figure (Figure 14) 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 several audit periods.

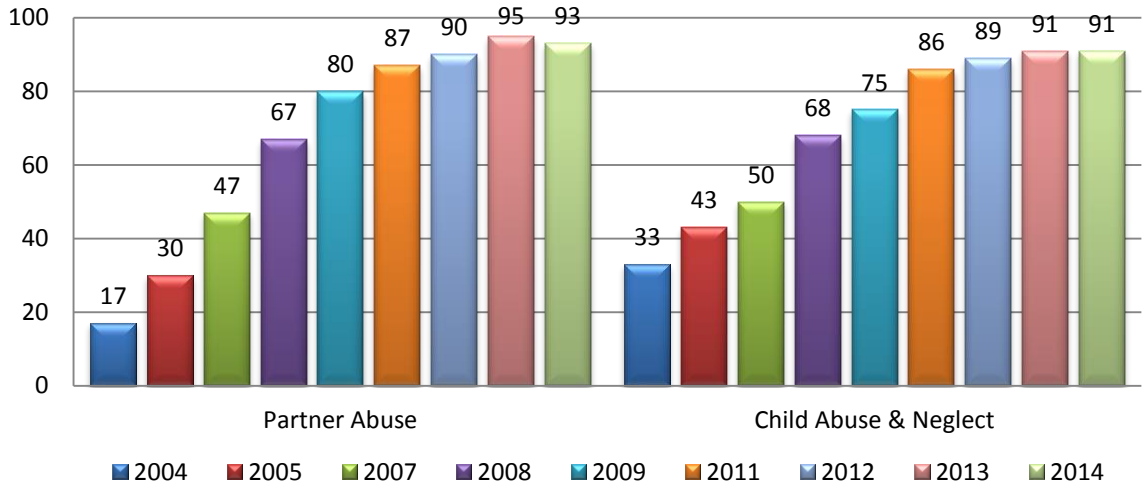


Figure 14. Median Hospital VIP Cultural Responsiveness Scores 2004-2014

Despite overall high median scores over several years, some indicators suggest that further development in *Cultural Responsiveness* is needed (Figure 15). For example, only ten (50%) of the twenty DHBs evaluated whether VIP Partner Abuse services are effective for Māori. It reduced to 8 (40%) DHBs in the CAN programme.

40% (n=8) of DHBs use a quality framework to evaluate whether child protection services are effective for Māori.

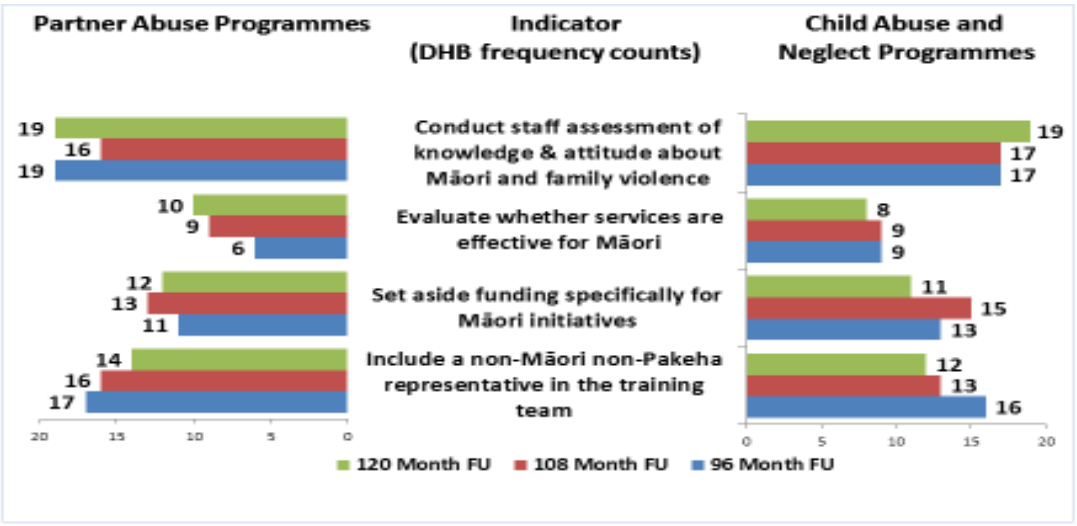


Figure 15. Selected Cultural Responsiveness Indicators (n=20 DHBs)

FINDINGS: PROGRAMME INFORMATION

All DHBs were requested to provide programme information as part of their Self Audit Report (Appendix D). The monitoring of VIP service and training implementation in all DHBs add to audit results obtained via the Delphi audit tools.

VIP IMPLEMENTATION

The Ministry funds DHBs to implement VIP (integrating partner abuse and child abuse and neglect services) in the following six targeted services: Child Health, Sexual Health, Alcohol and Drug, Maternity, Mental Health, and Emergency Department.

Many DHBs are still in the process of programme diffusion across services. The number of DHBs delivering VIP assessment and intervention by service increased between 2013 and 2014 (Figure 16). In some cases, such as sexual and mental health, services may be offered regionally. Some DHBs support VIP implementation beyond the identified Ministry targeted Services (such as in medical wards and primary health care services).

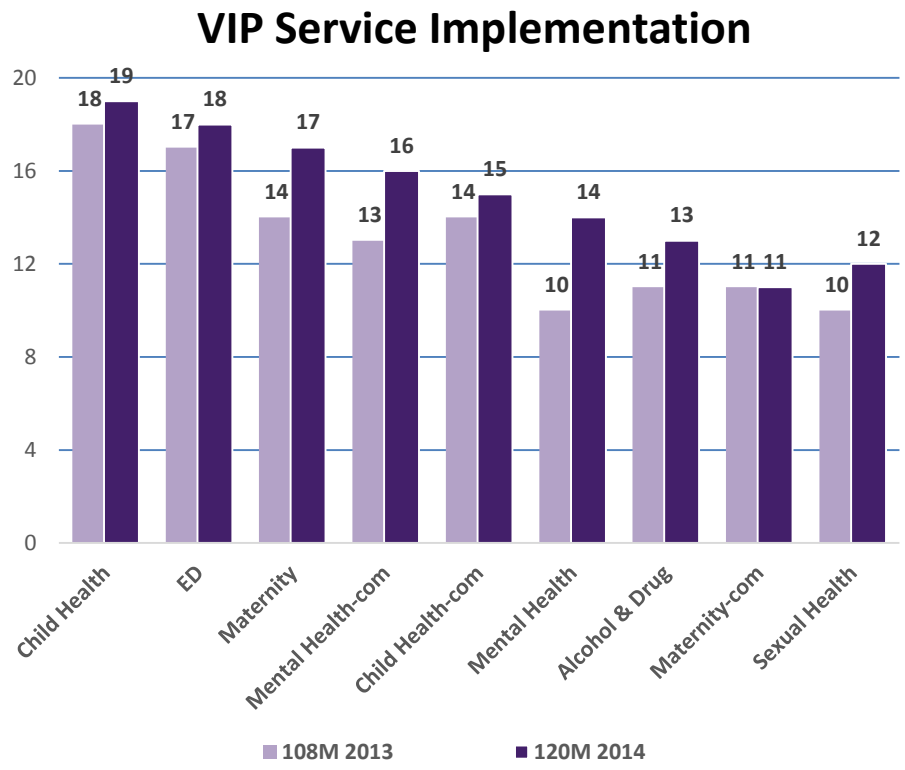


Figure 16. VIP Implementation by Service (number of DHBs)

Note: There are 15 Sexual Health Services and 17 Alcohol and Drug Services provided by DHBs nationally. Sexual Health and Alcohol & Drugs are Auckland regional services managed by Auckland and Waitemata DHBs respectively. Some DHBs have contracted NGOs, PHO, and GPs to provide the service. In the case of Alcohol & Drugs, two DHBs have amalgamated the service under the auspices of Community Mental Health.

CAPACITY DEVELOPMENT (TRAINING)

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. Only four DHBS were able to provide the data for all implementing services (though not necessarily for all professions). Training varied widely among health provider profession and among services.

In Emergency Departments, the proportion of doctors trained ranged from 5% to 30% (median 10%) in three reporting DHBs; and the proportion of nurses trained ranged from 40% to 100% (median 90%) in 11 reporting DHBs.

Five DHBs reported that in Sexual Health Services, doctors trained ranged from 30% to 100%, (median 100%) and nurses trained ranged from 70% to 100% (median 100%). Social workers trained ranged from 80% (Maternity Community) to 100% for all other targeted services. Including VIP training as a KPI would improve data collection regarding staff completion of core VIP training – and likely translate to improved service delivery.

INTERNAL AUDIT: PARTNER ABUSE SCREENING AND DISCLOSURE

VIP service specifications require DHBs to report on the level of partner violence screening being undertaken across six targeted services: Child Health, Emergency Department, Maternity, Mental Health, Sexual Health, and Alcohol & Drugs. At the 120 month follow-up, DHBs completed the VIP Snapshot surveys for Postnatal Maternity Admissions and Child Health Inpatient services. The Snapshot clinical audit data is presented in a later section (see page 28).

Partner abuse screening and disclosure is discussed below. Other potential measures of service delivery are the rates of completed risk assessment, including assessment of children in the home, and provision of specialised family violence services (at the time or through referral) to women who disclose abuse. Support for collecting this data is provided by the VIP Quality Improvement Toolkit, available to all DHBs.

PA Screening. In the PA Delphi tool, DHBs are asked to provide a summary statistic for the proportion of eligible women screened for partner violence (Appendix I, Screening and Safety Assessment Domain, PA Delphi item 5.2, page 66). In the 120 month 2014 audit, 10 (50%) DHBs reported screening at least half of eligible women, an increase from 6 (30%) and 9 (45%) at the 96 and 108 month follow up evaluations.

We present below clinical audit data submitted to the evaluators in their Programme Information reporting (Appendix D, page 50). As in previous audits,[43] there was significant variation in audit processes and reporting (e.g., time period sampled, number of records sampled, incomplete data). The summary data in this section, therefore, are indicative only.

Of the four non-Snapshot targeted services, one DHB (5%) provided clinical audit data for all four services, three provided data for three services and 5 DHBs did not provide any screening or disclosure data. This is likely due to insufficient capability and capacity for routine performance monitoring. The lack of electronic data systems for family violence data is a serious limitation to the collection of data across the sector.[44]

The reported screening rates are provided in Table 4 and Figure 17. Among reporting DHBs, the median proportion of eligible women screened by service ranged from 33% for the Emergency Department (with 14 DHBs reporting) to 74% for Sexual Health (with 7 DHBs reporting). These indicative screening rates are being reported to inform programme improvements. They indicate the need for quality improvement activities to increase the reliability of delivering a quality, consistent service to women.

System reliability is achieved when a standard action occurs at least 80% of the time.[45] Therefore, the VIP aim is to achieve a PA screening rate of 80% or greater (reference line in Figure 17). While the median screening rate did not achieve this standard for any service, there were 10 individual DHB service units that achieved a screening rate ≥ 80%. These locations present an opportunity to study what factors promote best practice.

A partner abuse screening rate of 80% or greater is indicative of system reliability.

Table 4: Indicative Partner Abuse Screening Data by Service

Service	No. DHBs Implementing VIP in service	No. DHBs reporting performance data	No. eligible records reviewed Range	Screening Rate Range	Screening Rate Median
Child Health Inpatients	19	See VIP Snapshot - Child Health Inpatients			
Maternity Inpatient	17	See VIP Snapshot - Postnatal Maternity			
Sexual Health	11	7	20-154	50-100%	74%
Child Health Community	15	6	20-327	0-100%	68%
Mental Health Community	16	4	5-186	10-70%	46%
Mental Health	14	6	4-40	10-100%	44%
Maternity Community	11	3	20-60	12-80%	42%
Alcohol & Drug	13	2	40-205	9-73%	41%
Emergency Department	18	14	10-3121	0-100%	33%

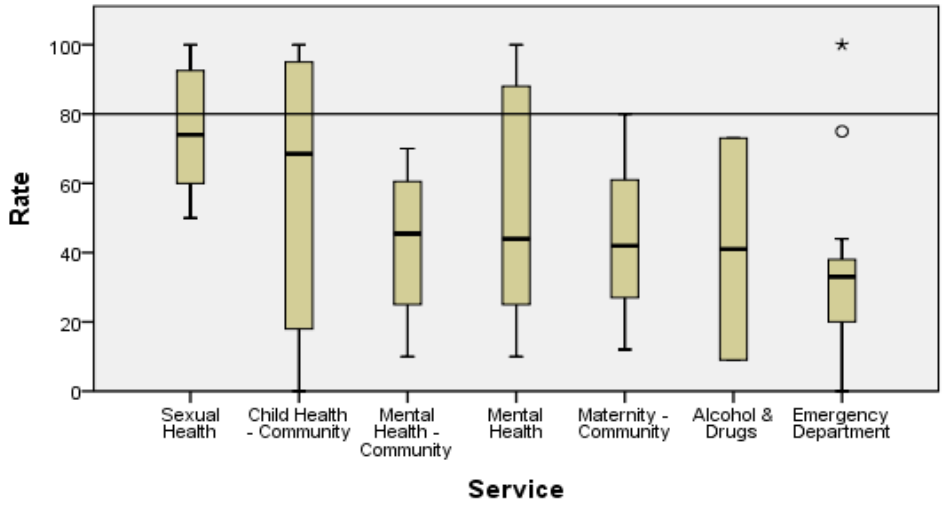


Figure 17. Indicative Partner Abuse Screening Rate by Service (Non-Snapshot)

PA Disclosure. One measure of screening quality is the rate of partner violence identified as a result of direct questioning, the 'disclosure rate'. Research and practice identify that the quality of screening (including the environment, screening knowledge and attitude) will influence whether or not a woman will choose to disclose abuse.[46-48] With the estimated New Zealand population past year partner violence prevalence rates among women of 5%,[6,49] we would expect disclosure rates among women seeking health care to be at least that, and most likely higher given a higher use of health services among women who experience abuse.[50-52] Disclosure rates (based on screening for past year prevalence) would be expected to vary across services, with higher rates for example in mental health, alcohol and drug and sexual health services.

Among every twenty women screened for partner abuse, we expect one or more to disclose abuse.

The disclosure rates reported by DHBs are provided in Table 5 and Figure 18. Similar to screening data, there was significant variation in audit processes and reporting of disclosure data. There was variation in the number of DHBs reporting data (1 to 13), sample size, length of audit, and the number of eligible records reviewed (Table 5). Among women who were screened for partner abuse, the median disclosure rate was greater than the population prevalence rate in Mental Health (inpatient and community services), Alcohol and Drug services and Sexual Health. In one DHB, over half of the screened women in Mental Health Inpatient and Mental Health Community Services disclosed abuse. Many services within DHBs reported a disclosure rate below 5% (reference line in Figure 18). A focus on standardisation, accurate reporting and ongoing quality improvement activities is expected to improve results. Implementing quality improvement strategies following the IHI Model for Improvement, with rapid plan-do-study-act cycles, is a useful method to learn about systems and increase the delivery of safe, sensitive partner violence assessment and intervention.[25]

Table 5. Partner Abuse Disclosure Data by Service

Service	No. of DHBs reporting disclosure data	No. eligible records reviewed	Disclosure Rate Range	Disclosure Rate Median
Child Health Inpatients	See VIP Snapshot – Child Health Inpatients			
Maternity Inpatient	See VIP Snapshot – Postnatal Maternity			
Mental Health	6	4-40	0-50%	20%
Alcohol & Drug	3	40-205	6-24%	18%
Mental Health Community	4	5-186	15-50%	17%
Sexual Health	7	20-154	0-25%	8%
Child Health Community	6	20-327	0-21%	4%
Emergency Department	13	10-3121	0-30%	3%
Maternity Community	4	20-60	0-1%	0%

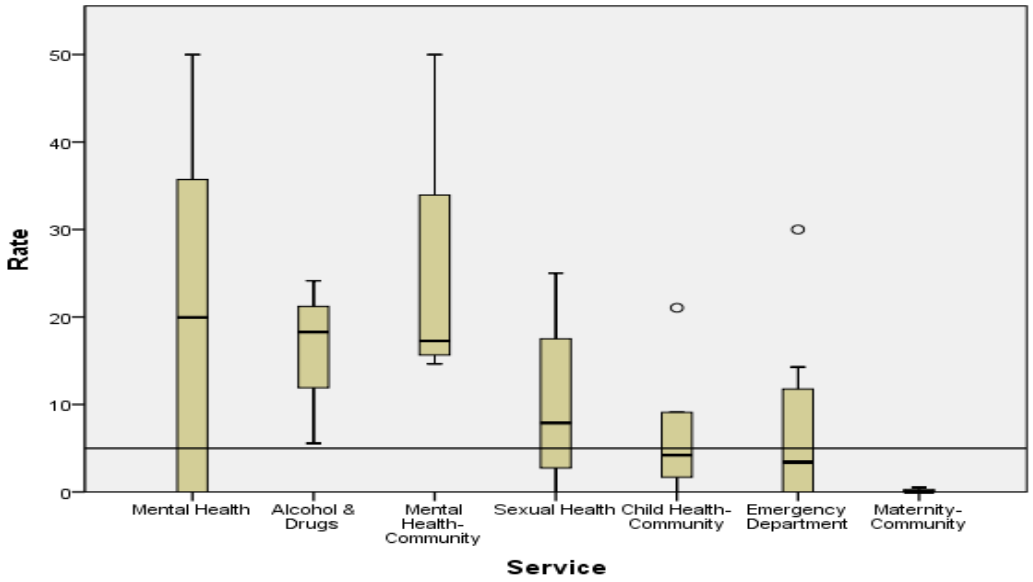


Figure 18. Indicative Partner Abuse Disclosure Rate by Service (Non-Snapshot)

INTERNAL AUDIT: REPORT OF CONCERN REFERRALS MADE TO CHILD, YOUTH & FAMILY

With system development advancing, there is increasing attention on evaluating service delivery. Monitoring child protection systems and programmes includes measuring prevention before maltreatment occurs and provision of services once maltreatment is identified. As many recognise, however, measuring outcomes and impact is 'exceedingly challenging' to implement.[53,13,41,54]

The VIP Quality Improvement Toolkit includes a worksheet entitled *Child, Youth and Family Referral Clinical Audit Tool* to facilitate internal review. In the 2014 evaluation, DHBs self-reported summary data regarding their reviews of clinical records and Reports of Concern (ROC) to Child, Youth and Family (Appendix D). Data was provided by 15 (75%) DHBs. The period of review varied across the reporting DHBs, from 1 to 13 months, and the total number of Reports of Concern made during the variable audit periods ranged from 3 to 757. The purpose of the audit is to identify documentation standards when a referral is made to Child, Youth and Family.

Among reporting DHBs, the number of clinical records and ROC reviewed ranged between 3 and 405, representing review of between 7% and 100% of eligible records during the review period. Among reviewed records, partner abuse assessment was typically documented 30% of the time (range 16%-100%), child maltreatment was included in the medical diagnoses 49% of the time and child protection concerns were included in the Discharge Summary 39% of the time. These data indicate a need for improvement in the consistent documenting of child protection concerns when a referral to Child, Youth and Family is initiated.

FINDINGS: SNAPSHOT

VIP is not fully implemented throughout all DHBs in the Snapshot designated services. For example, 85% (n=17) of DHBs have implemented VIP in Postnatal Maternity inpatient services; 90% (n=18) have implemented VIP in Child Health inpatient services and in the Emergency Department / Children's Emergency Department. To estimate the output and outcome of VIP nationally, all DHBs were requested to audit these services irrespective whether VIP was fully, partially or not implemented in that particular service. Of note, two DHBs provided data separately for two hospital locations to facilitate understanding of performance across the two sites.

The key findings of the inaugural VIP Snapshot audits are below. They include population estimates for women who are screened, disclosed and received referrals and the estimated CAN populations for children under two years of age who presented to ED for any reason.

PARTNER ABUSE ASSESSMENT & INTERVENTION

Postnatal Maternity

Nationally, 20 DHBs provided data from 22 postnatal maternity locations. They reported that 9,003 women were admitted during the three month audit period (1 April – 30 June 2014). Random sampling from the 22 locations resulted in 549 cases audited for the 2014 Snapshot.

The PA postnatal maternity snapshot screening rate ranged from 0% to 72% across the DHBs (Figure 19). Both Northland and Taranaki DHBs achieved a screening rate of 72%, nearing the target rate of greater than 80%. Among the three DHBs with 0% screening, two had not yet implemented VIP in the postnatal maternity service at the time of the audit.

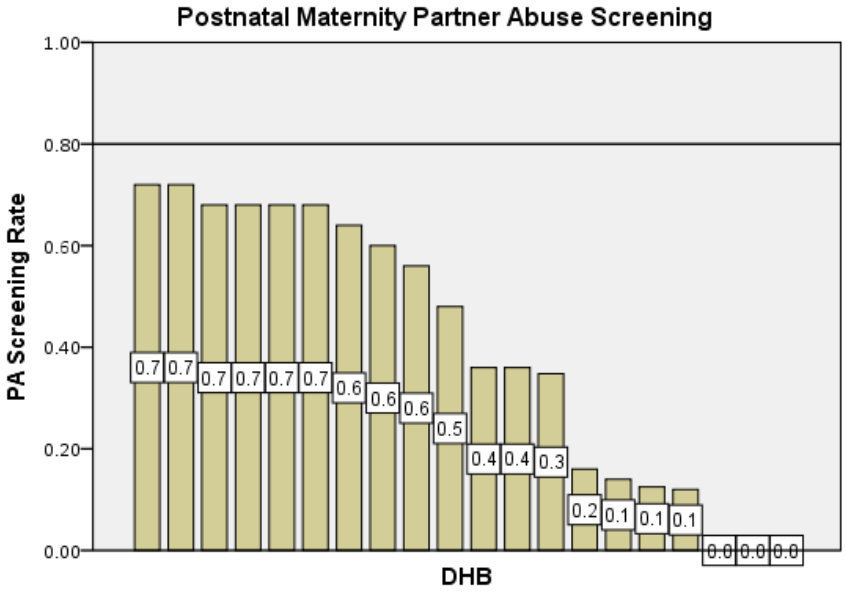


Figure 19 Distribution of Partner Abuse Screening Rates Across DHB Postnatal Maternity (N=20)

Among women who were screened, PA disclosure rates ranged from 0% to 25% across the 17 DHBs with a nonzero screening rate (Figure 20). Eight DHBs met the expectation that at least one of every twenty women screened would disclose abuse. The DHBs were: Counties Manukau, Whanganui, Bay of Plenty, Tairawhiti, South Canterbury, Taranaki, Hutt Valley and Wairarapa.

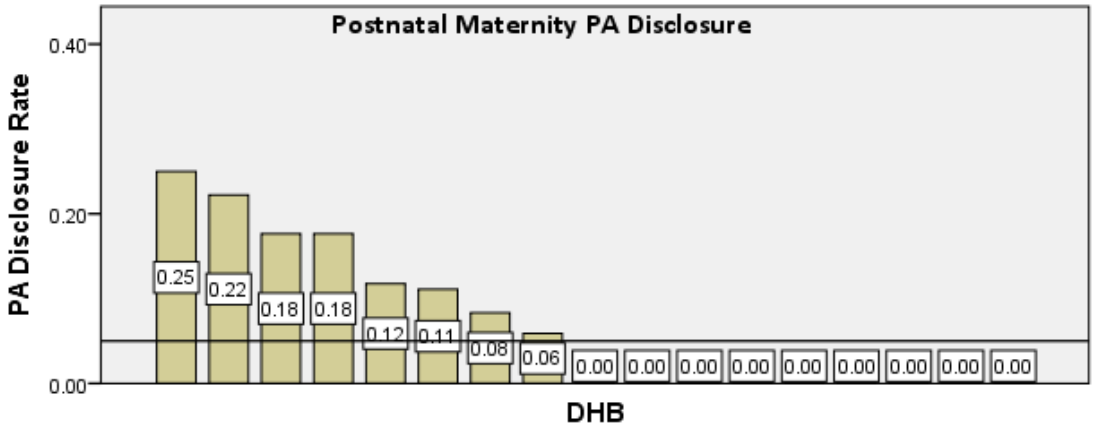


Figure 20. Distribution of Partner Abuse Disclosure Rates Across DHBs (n=17)

Among women who disclosed PA, referral rates ranged from 0% to 100% across DHBs. Half of the referrals (50%) were active referrals, meaning the women received a family violence specialist service (such as a social worker or Women's Refuge advocate) onsite. In contrast, offsite referrals involved providing specialist contact information (e.g., pamphlets) for the women to follow up at her discretion.

As stated earlier in this report, a partner abuse screening rate of 80% or greater is indicative of system reliability (see page 25); and given the population prevalence, a disclosure rate of 5% or greater is expected as an indicator of screening quality (see page 26).

In the postnatal maternity services, no DHBs achieved these benchmarks (Figure 21, 'target zone'). That said, five DHBs (Bay of Plenty, Tairawhiti, South Canterbury, Taranaki and Wairarapa) achieved a greater than 60% screen rate with a disclosure rate at 5% or above for the VIP Postnatal Maternity Snapshot.

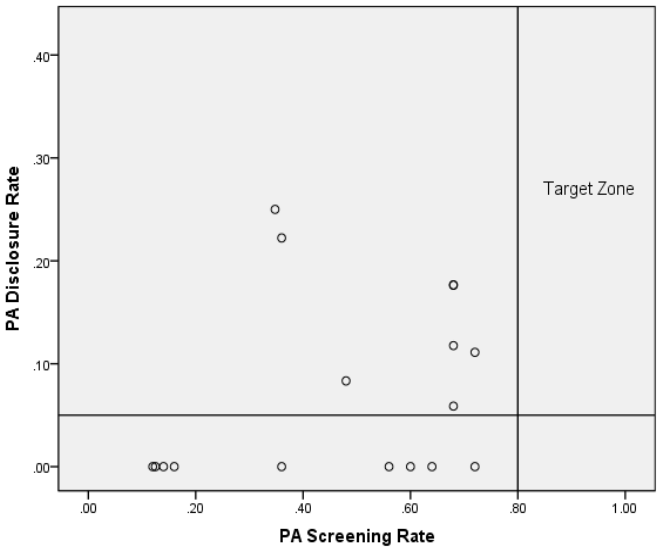


Figure 21. Plot of DHB Partner Abuse Screening and Disclosure Rates for Postnatal Maternity Services

Based on the Snapshot weighted mean for PA screening (33%; 95% CI 26%, 39%), we estimate that 2,935 women admitted to postnatal maternity services during the second quarter of 2014 received a VIP partner abuse screen (see Table 6).

Based on the Snapshot data weighted mean for PA disclosure (9%, 95% CI 3%, 19%), we also estimate that 257 women disclosed partner abuse to a health care provider, with 193 (75%) women receiving a referral for specialist services (50% on and off site). Importantly, we estimate that 96 women received an onsite specialist consultation during her admission.

Table 6. **Postnatal Maternity services -** Population estimates of women who received partner abuse (PA) screening intervention (April-June 2014)

Reported PA Screening, Dislcosure and Referral Rates	Number	95% CI
Eligible Women admitted to service	9003	
Estimated number of women who were screened for PA	2935	2375, 3512
Estimated number of women who disclosed PA	257	96, 419
Estimated number of women who received referrals:	193	
To onsite specialist services: 96		
To off site specialist services: 96		

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 12,592 children were admitted during the three month audit period (1 April – 30 June 2014). Random sampling from the 22 locations resulted in 1,080 cases audited for the 2014 Snapshot.

The PA child health inpatient snapshot screening rate of female parents, guardians or caregivers, ranged from 0% to 100% (Figure 22). Both Waitemata and West Coast DHBs achieved the target screening rate of greater than 80%. The two DHBs who had not fully implemented VIP in child health inpatient services had a screening rate lower than 25%.

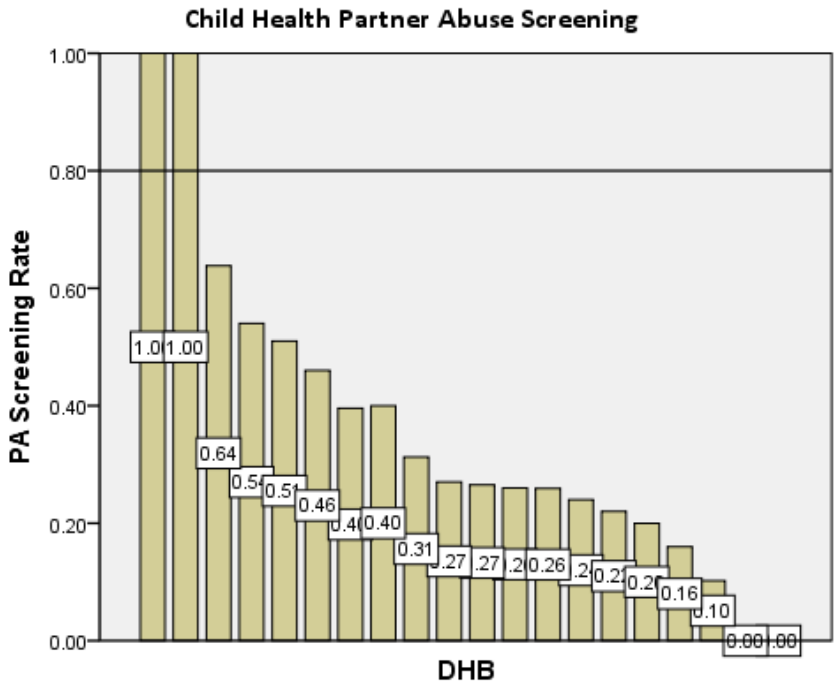


Figure 22. Distribution of Partner Abuse Screening Rates Across DHB Child Health (n=20)

Among women who were screened, disclosure rates ranged from 0% to 32% across the 18 DHBs with a nonzero screening rate (Figure 23). Nine DHBs met the expectation that at least one of every twenty women screened would disclose abuse. The DHBs were: Tairawhiti, Southern, Wairarapa, Auckland, Bay of Plenty, Capital & Coast, Counties Manukau, Taranaki and Hawkes Bay.

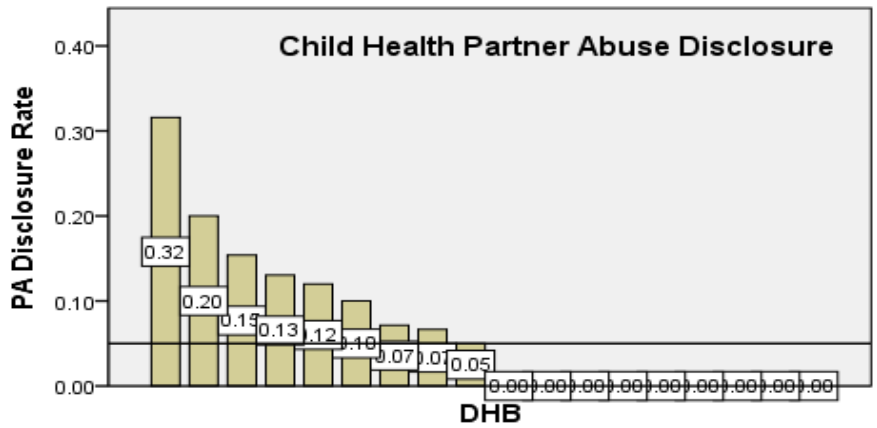


Figure 23. Distribution of Partner Abuse Disclosure Rates Across DHB Child Health (n=18).

Among women who disclosed PA, referral rates ranged from 0% to 100%. Half of the referrals (50%) were active referrals, meaning the women received a family violence specialist service (such as a social worker or Women's Refuge advocate) on site. In contrast, offsite referrals involved providing specialist contact information (e.g. pamphlets) for the women to follow up at their discretion.

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. In child health services, no DHBs achieved these benchmarks (Figure 24; Target Zone). That said, five DHBs (Taranaki, Bay of Plenty, Auckland, Tairawhiti and Hawkes Bay) achieved a 40% or greater screen rate with disclosure rate at 5% or above for the VIP Chid Health Snapshot.

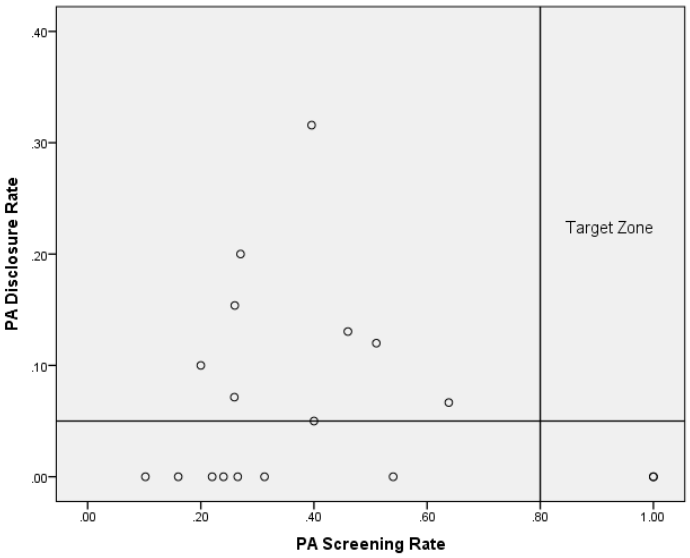


Figure 24. Plot of DHB Partner Abuse Screening and Disclosure Rates for Child Health Inpatient Services

Based on the Snapshot weighted mean for PA screening (39%; 95% CI 31%, 48%), we estimate that 4,869 female caregivers of children admitted to general paediatric wards during the second quarter of 2014 received a VIP partner abuse screen (see Table 7).

Based on the Snapshot data weighted mean for PA disclosure (6%; 95% CI 4%, 9%), we also estimate that 259 women disclosed partner abuse to a health care provider, with 181 women receiving a referral for specialist services (equally split between onsite and off site). Importantly, we estimate that 90 women received an onsite specialist consultation during her admission.

Table 7. **Child Health Inpatients** - population estimates of women who received partner abuse (PA) screening and service (April-June 2014)

Reported PA Screening, Dislcosure and Referral Rates	Number	95% CI
Children admitted to service	12592	
Estimated number of female caregivers screened for PA	4869	3787, 5951
Estimated number of female caregivers who disclosed PA	259	191, 328
Estimated number of women who received referrals:	181	
To onsite specialist services: 90		
To off site specialist services: 90		

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

CHILD ABUSE & NEGLECT ASSESSMENT & INTERVENTION

Emergency Department

Nationally, 19 DHBs (95%) provided data from 20 children's/emergency department locations. The non-contributing DHB was unable to select a random sample of files for children under two years of age due to IT issues. From the 19 reporting DHBs, 15,535 children under two years presented for any reason to the emergency department during the three month audit period (1 April – 30 June 2014). Random sampling from the 19 locations resulted in 566 cases audited for the 2014 Snapshot.

The CAN snapshot child protection assessment rate, for children under two presenting to ED for any reason, ranged from 0% to 61% across the DHBs (Figure 25).

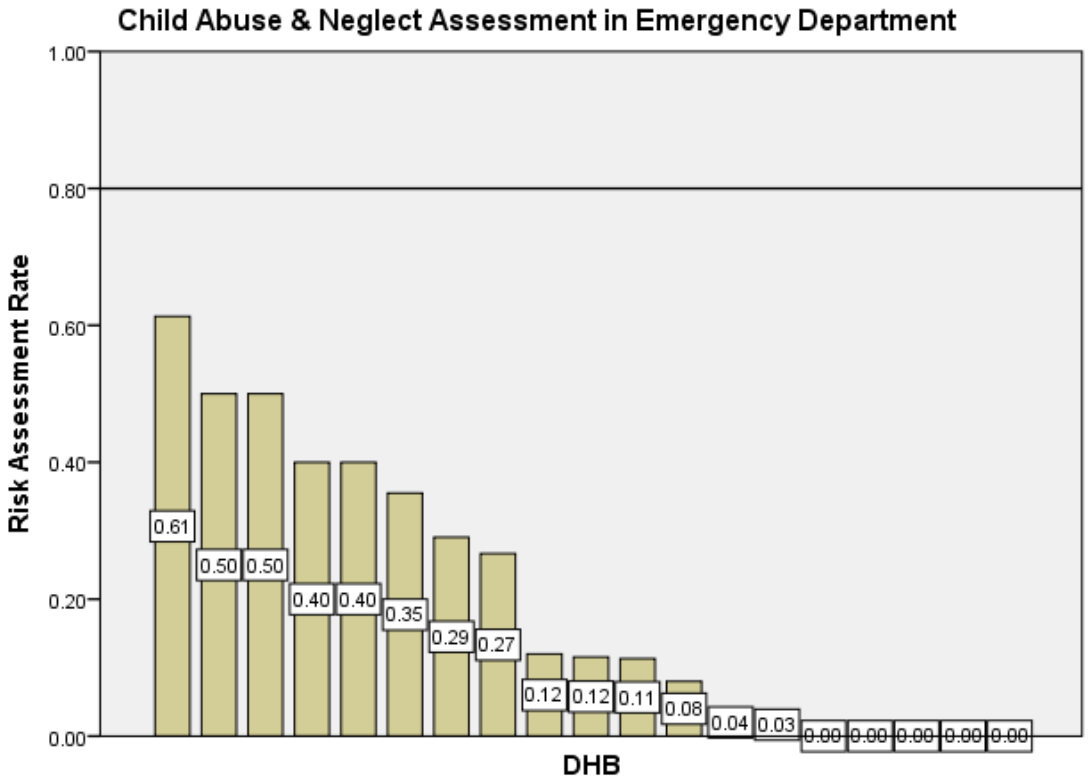


Figure 25. Distribution of Child Abuse & Neglect Assessment Rate Across DHB Emergency Departments

Among the 14 DHBs that had a child abuse and neglect assessment rate greater than zero, five identified a CAN concern (one or more positive indicators) in one or more children. Sample sizes were small; in the 122 cases that had documentation of a CAN assessment , 18 had documented a concern. Among the 18 children with child protection concerns, 16 had evidence of a specialist child protection consultation.

Based on the Snapshot weighted mean for CAN assessment (27%; 95% CI 20%, 34%), we estimate that 4,163 children under two years of age seen in an acute hospital emergency department were assessed for abuse during the second quarter of 2014 (see Table 8).

Based on the Snapshot data weighted mean for CAN identification of risk factors (13%; 95% CI 8%, 18%), we also estimate that 549 children had a CAN concern identified.

Table 8. **Emergency Department** population estimates of children under two years of age who received CAN assessment and service (April-June 2014; 19 DHBs reporting)

Reported Assessment, Identification of Concern and Specialist Consultation	Number	95% CI
Children presenting to ED under 2 years for any reason	15535	
Estimated number of children assessed for CAN indicators	4163	3096, 5229
Estimated number of children with one or more positive CAN indicators	549	348, 750
Estimated number of children whose cases were reviewed for CAN with specialist	489	

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

VIP SNAPSHOT ETHNICITY DATA

Assessment rates for partner abuse (in postnatal maternity and child health) and child abuse and neglect (in emergency department for children under 2 years) were examined for Māori and non-Māori (Table 9). Non-Māori were less likely to receive VIP assessment services for children under two seen in emergency departments (OR=0.56), and in postnatal maternity services (OR=0.75). This raises the question as to why Māori and non-Māori are being treated differently, though both being underserved (less than 80% assessment rates). It will be important to follow the pattern of VIP implementation across ethnicity in future Snapshot audits.

Table 9. VIP Assessments by Ethnicity

Ethnicity	PA Screening		CAN Screening
	Postnatal Maternity	Child Health Inpatients	Emergency Department
Non Māori	160/429 (37%)	266/726 (37%)	72/391 (18%)
New Zealand Māori	53/120 (44%)	110/336 (33%)	50/175 (29%)

DISCUSSION

New Zealand District Health Boards have maintained infrastructure developments indicative of a system response to persons experiencing family violence. All but one DHB (n=19) has achieved a high score (>80) in partner abuse and all have achieved high scores in their child abuse and neglect programme infrastructure audits. Established programme components include policies and procedures, leadership and governance and collaboration with local government and non-government specialist family violence services. Standardised one day training programmes for clinical staff are supported by service level clinical champions and FVI Coordinators. While programmes are doing well overall, there remains gaps and risks to programme sustainability. For example, DHB turnover (and resulting hiatus) for VIP sponsors, managers, coordinators and clinical champions stymies progress. In addition, some indicators, such as evaluating the effectiveness of the programme for Māori, have been achieved in a minority of DHBs. Ongoing partnership among DHB Māori Health Units, iwi and the VIP DHB Teams is needed to improve VIP DHB responsiveness to Māori.

The introduction of the VIP Snapshot audits provides standardised partner violence and child abuse and neglect screening data to measure performance and to inform improvements. We identified wide variation between and within DHBs in the provision of VIP services, both in the assessment and identification of abuse. For example, within one DHB, the partner abuse screening rate in a given service was 0% in one location and 72% in another.

Nationwide, approximately one of every three women admitted to postnatal maternity services or caring for a child admitted to child health inpatient service will be assessed for partner abuse. It is important to now translate audit information into quality improvements. On-going workforce development support for applying quality improvement methodologies and learning from high performing services are recommended. The *VIP Quality Improvement Toolkit,* VIP PDSA Worksheet and the VIP national management team are current resources to assist programmes to move from testing improvements to implementing and sustaining achievements.

In this inaugural Snapshot assessment, we found that only one of every four (27%) children under two years of age presenting to an emergency department had an assessment that included child protection indicators. Although there is debate about individual indicators, and the predictive value of a positive standardised assessment is unknown, Sittig and colleagues summarise that, “Professionals are urged to be explicitly aware of child abuse as one of the differential diagnoses”.[36] A protocol of standardised assessment to rule out child protection risks raises awareness of child abuse and neglect and increases the number of cases identified as requiring consultation.[37,38,55] The 2014 Snapshot findings are a starting point from which to support and monitor improvements in the consistency of a thorough clinical assessment for children presenting to the emergency department under the age of two.

We acknowledge the interagency work being undertaken by the Children’s Action Teams, Child, Youth and Family, Police and the Ministries of Social Development, Education, Justice and Health and other agencies to identify, support and protect vulnerable children, women and families. Recognising violence as a significant public health issue, the Ministry of Health enables the health response to family violence through the Violence Intervention Programme. VIP offers a systems approach within a cross-agency network of government and civil society. Improved measurement in service delivery and outcomes and impact will assist health and others to guide and monitor the achievement of our goal to prevent family violence in New Zealand.

Ongoing workforce development, strong management support, additional resources, technical IT support, and more rigorous and consistent internal audit process to improve service quality, are still needed. The burden of manual chart review across services and the limited ability to undertake electronic chart reviews remains a barrier. A nationwide health target for Family Violence that includes violence against women as well as children in its remit would spur comprehensive strategies to bring all DHBs up to a required standard.

EVALUATION STRENGTHS AND LIMITATIONS

Strengths of this evaluation project include using established family violence programme evaluation instruments[27,29,30] and following standard quality improvement processes in auditing.[56,57] The project promotes a comprehensive systems approach to addressing family violence, a key characteristic for delivering effective services.[4,20,29,32]

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.

In 2014 all DHBs participated in the inaugural VIP Snapshot surveys in three DHB services. The Snapshots will be extended to include additional MoH targeted services in 2015 and beyond.

Our processes of audit planning, site visits 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,[58] 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 2014).

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 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 will be reviewed in 2015 to guide programme maintenance and sustainability.

- The VIP audit does not include indicators related to the Family Violence Intervention Guidelines: Elder Abuse and Neglect,[59] or the Shaken Baby Prevention Programme[60] being introduced throughout DHBs, even though an increasing number have endorsed policies for both.

- Among the 1,080 admitted children's records that were reviewed for the Snapshot audit of partner abuse screening of female caregivers, some children's records (n=18) had documentation of no eligible female caregiver.

- The Snapshot sample size for individual DHBs were small (n=25 or 50), with resulting wide confidence intervals. In some DHBs for example, out of the 25 cases they may have had 15 that met the standard for partner abuse screening, with one disclosure.

VIP PRIORITIES FOR 2015 and 2016

- VIP to be fully implemented in all MOH targeted services in all DHBs

- VIP to support DHBs to update their processes aligned to the expected revised Ministry of Health Family Violence Intervention Guidelines: Child and Partner Abuse (*The Guidelines*) in 2015.

- DHBs to focus on improving the identification, assessment, and responses to vulnerable children, women, their families/whānau.

- Service delivery for women, children and whānau experiencing family violence to be audited by the VIP Snapshot audit process.

- Quality improvement and evaluation activities evaluated nationally to improve VIP outcomes in all DHBs.

- The National Child Protection Alert Systems to be implemented in all DHBs.

- Standardised national IT solutions to enable electronic monitoring of VIP by DHB and service to be investigated and implemented over time.

- VIP infrastructure evaluation to be enhanced by a review of the current PA and CAN Delphi tools to ensure that the domains and indicators meet current practices, new MoH guidelines and programmes (e.g. Elder Abuse and Neglect, Shaken Baby Programmes) underway in DHBs and to support the ongoing sustainability of the VIP Programme in DHBs.

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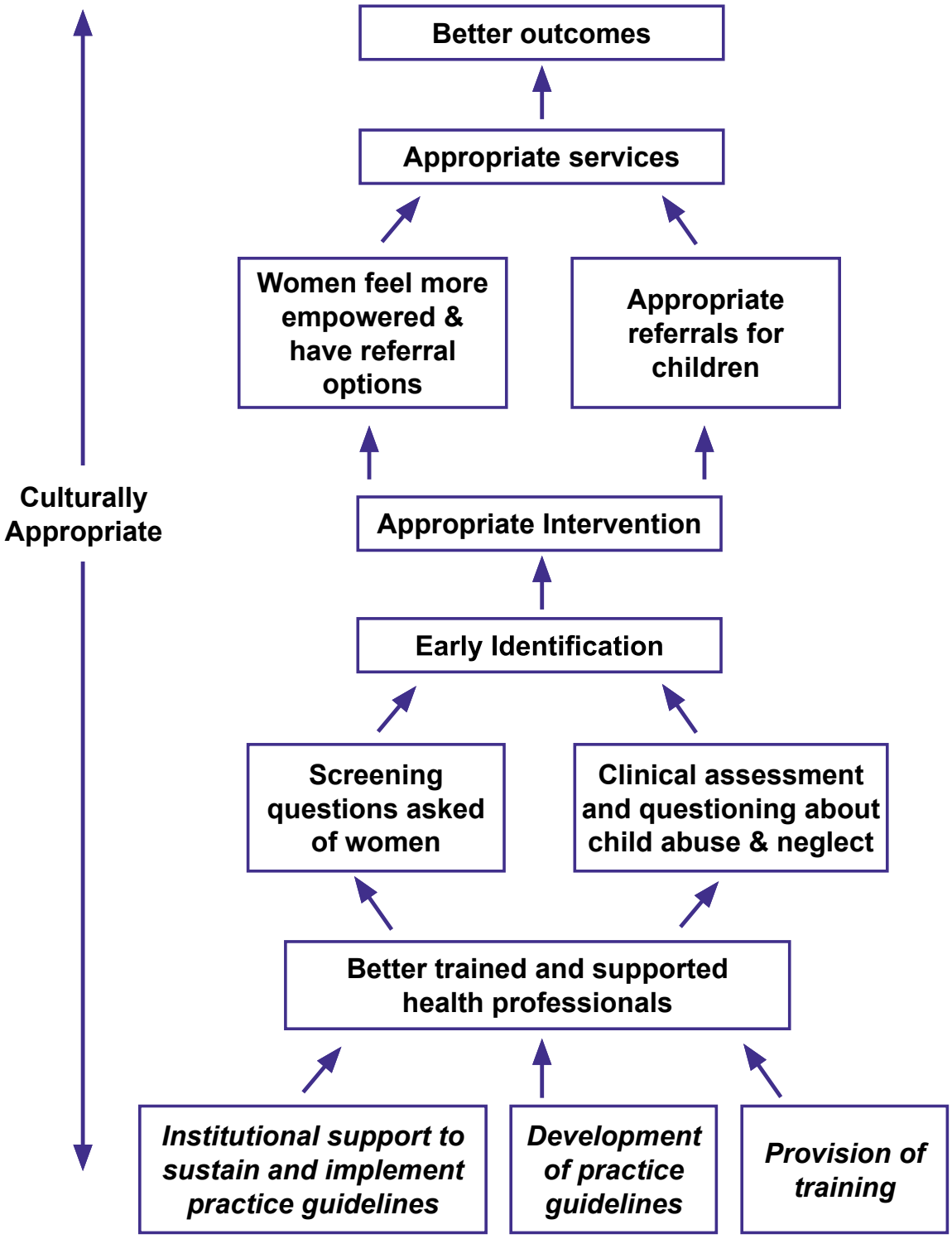
APPENDICES

APPENDIX A: Family Violence Project 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

S = secondary service, T = tertiary

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

APPENDIX C: VIP Snapshot Audit Information Sheet

(Letterhead removed)

VIP SNAPSHOT 2014 15 November 2014

This simple online system has been developed by AUT in response to the Ministry of Health's 2012/15 DHB VIP contracts that require DHBs to undertake snapshot audits in 2014 and 2015.

Audit Period is from 1 April to 30 June 2014.

Sample Size: Random samples of patient files are to be retrospectively selected from the review period:

Partner Abuse Clinical Audit:

- Postnatal Maternity Admissions 25 files
- Child Health Inpatients (Female guardians, parents or Caregivers assessed for partner abuse) 50 files

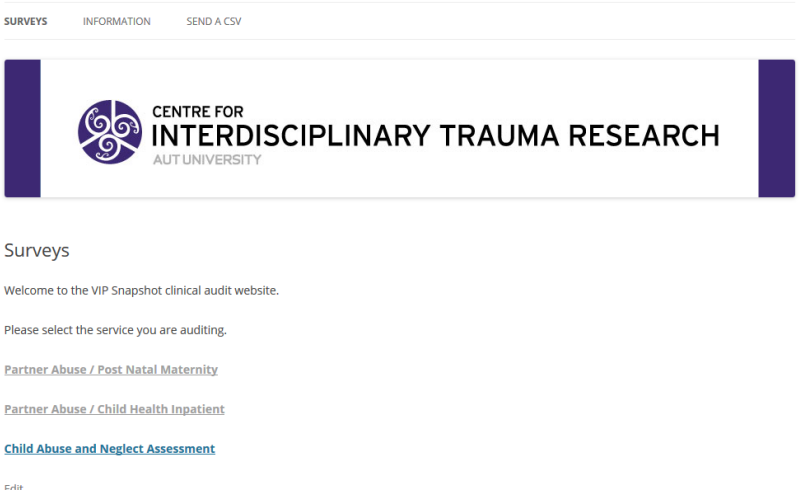
Child Abuse & Neglect Clinical Audit:

- All children under two presenting to Emergency Services 25 files

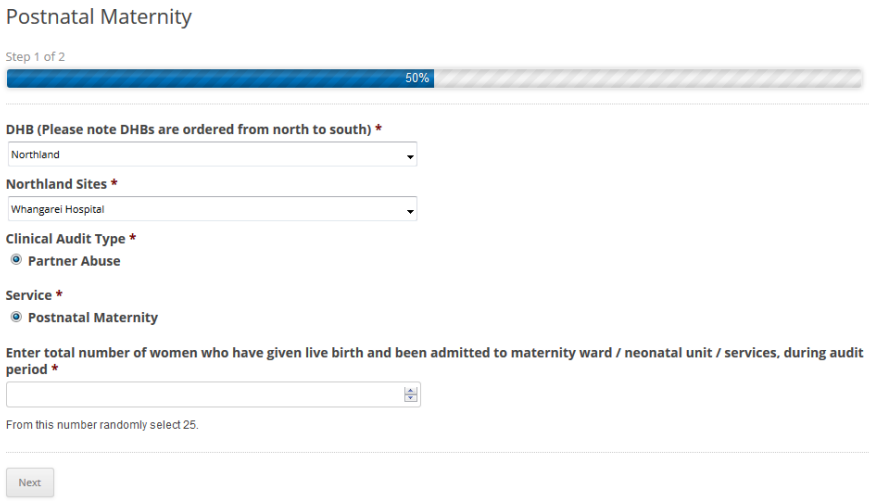
Sites: Main sites only should be reported on if there are satellite sites and many services.

Instructions

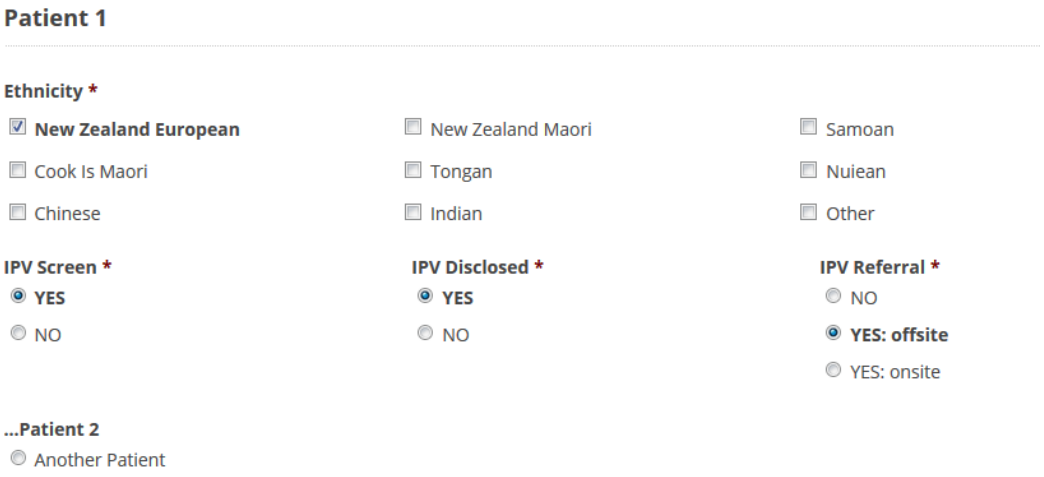
- The VIP Snapshot system is accessed on https://vipsnapshot.aut.ac.nz
- Please place your cursor over this URL, click ctrl+ click.
- Please use your user name and password that have been sent to you to enter the system.
- Click on the service you are auditing to enter the data collection system.



- Please select your DHB, site and clinical audit type.



- Enter the total number of women eligible during audit period
- Please complete Patient 1 details, click on Patient 2 for next patient.
- Continue until required number of files is entered.



- Similar format for other three audits.

USER NAMES and PASSWORDS

User names and passwords are required for VIP Programme Co-ordinators from each DHB who will be undertaking the clinical audits and entering the audit data into the Snapshot system.

DATA ENTRY

- All data is to be entered into the VIP Snapshot system on an individualised file basis.
- If your DHB is able to provide the following information electronically, please do not upload the CSV or excel file into the system as there is a bug in it that we are working on.
- Please forward your CSV file to Chris McLean, christine.mclean@aut.ac.nz

ETHNICITY:

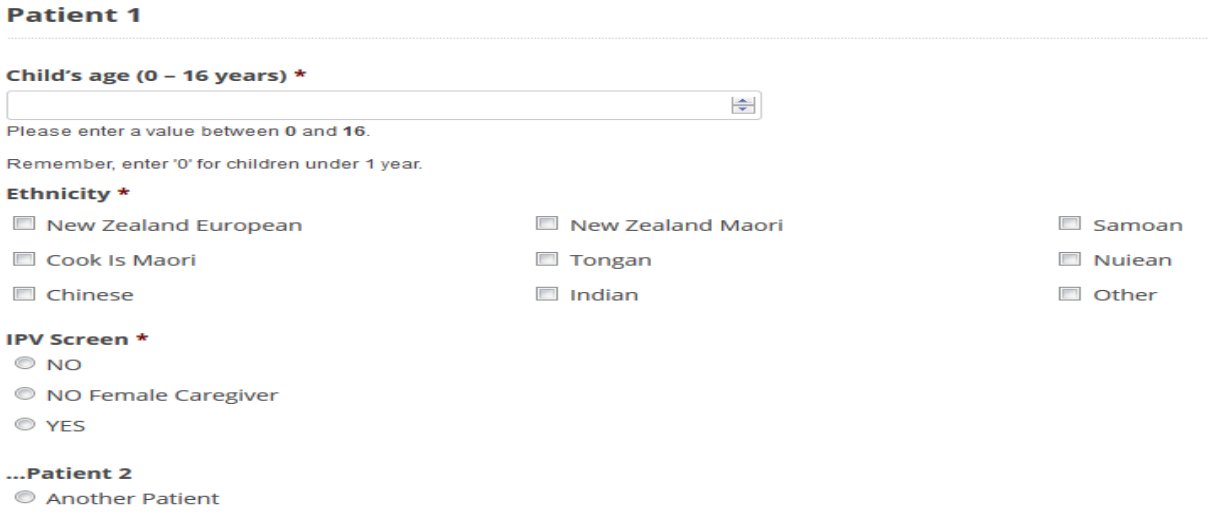
Select up to three ethnicities per patient. Ethnicities include:

New Zealand European
New Zealand Māori
Samoan
Cook Island Māori
Tongan
Nuiean
Chinese
Indian
Other

PARTNER ABUSE CLINICAL AUDIT - two services to be audited:

Child Health Inpatient

- **Enter total number of children (aged 16 and under) admitted to a general paediatric inpatient ward (not a specialty setting) during the review period.**
- **From these admissions, randomly select 50 files.**
- **Child's age. If under one, enter '0'.**



Definitions:

PA 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 that there is no female family caregiver in the household.
YES	There is documentation that the woman was screened for PA in the past 12 months according to the national VIP Guidelines. This would include asking the woman three or more screening questions.

NOTE: If a NO or NO female caregiver is ticked, by default the following two questions about Disclosure and Appropriate Referral questions are a NO (and do not appear).

PA Disclosure: Did the woman disclose PA?

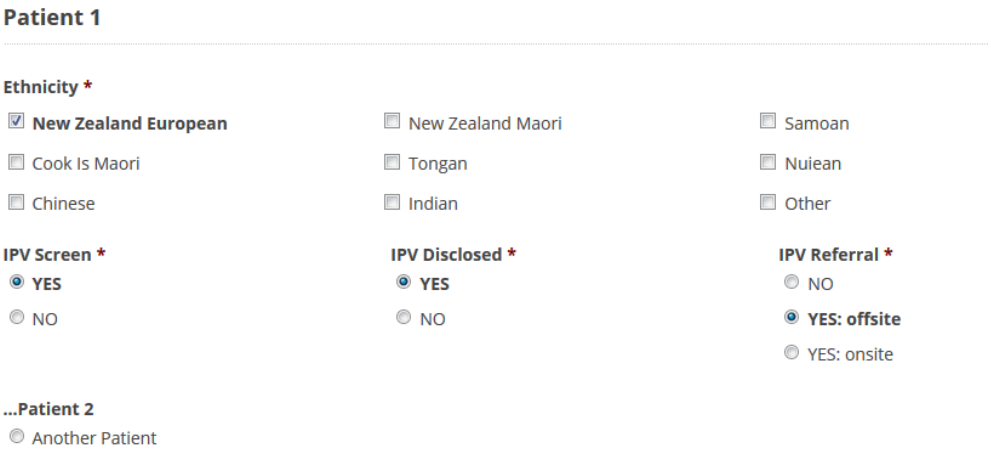
NO	**Woman did not disclose PA in the past 12 months.** If a woman was screened, but there is no documentation regarding disclosure, this is a 'NO'.
YES	**Woman disclosed abuse in** response to PA screening (abuse in the past 12 months or currently afraid). If woman disclosed abuse before screening, would still be a 'YES'.

PA Referrals: Were appropriate referrals made?

NO	No identification in notes that referrals were discussed, or notes indicate referrals but do not specify to whom or appear incomplete.
REFUSED	Documentation that referral was refused.
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 information, facilitating access to offsite services (e.g. Women's Refuge, community services).
YES: onsite	Immediate access to onsite support by a family violence specialist (such as a social worker, Women's Refuge advocate) who can provide victim with danger assessment, safety planning and access to community services.

Postnatal Maternity Admissions

- **Enter total number of women who have given live birth and been admitted to postnatal maternity ward during the audit period.**
- **From these admissions, randomly select 25 files.**



Definitions:

PA 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.

PA Disclosed: Did the woman disclose PA?

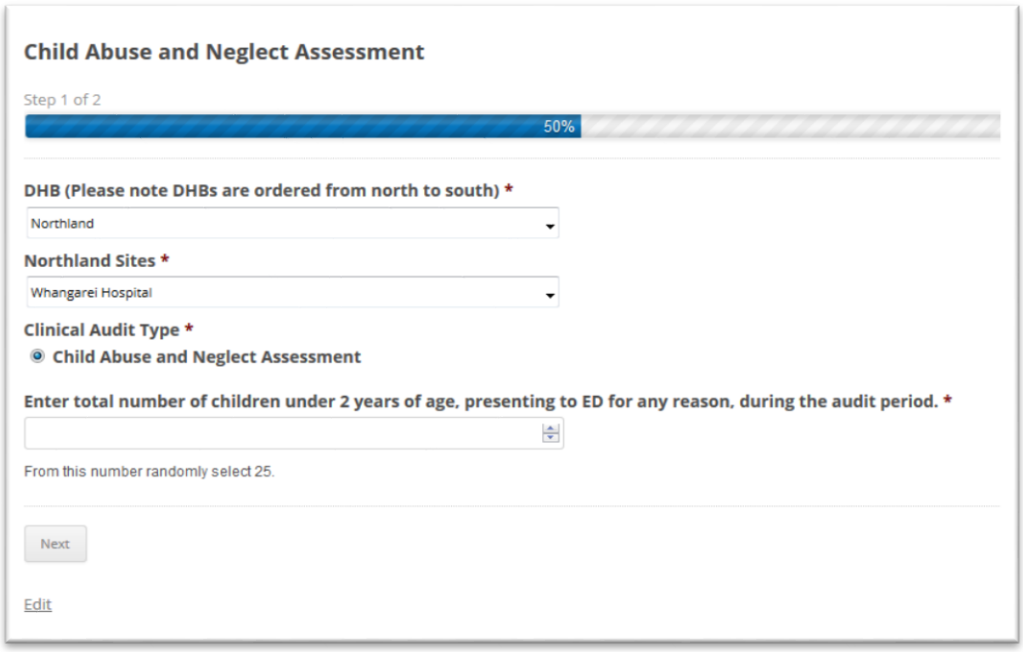
NO	Woman did not disclose PA. If a woman was screened, but there is no documentation regarding disclosure, this is a 'NO'.
YES	Woman disclosed abuse in response to PA screen (abuse in the past 12 months or currently afraid). **If woman disclosed abuse before screening, would still be a 'YES'.**

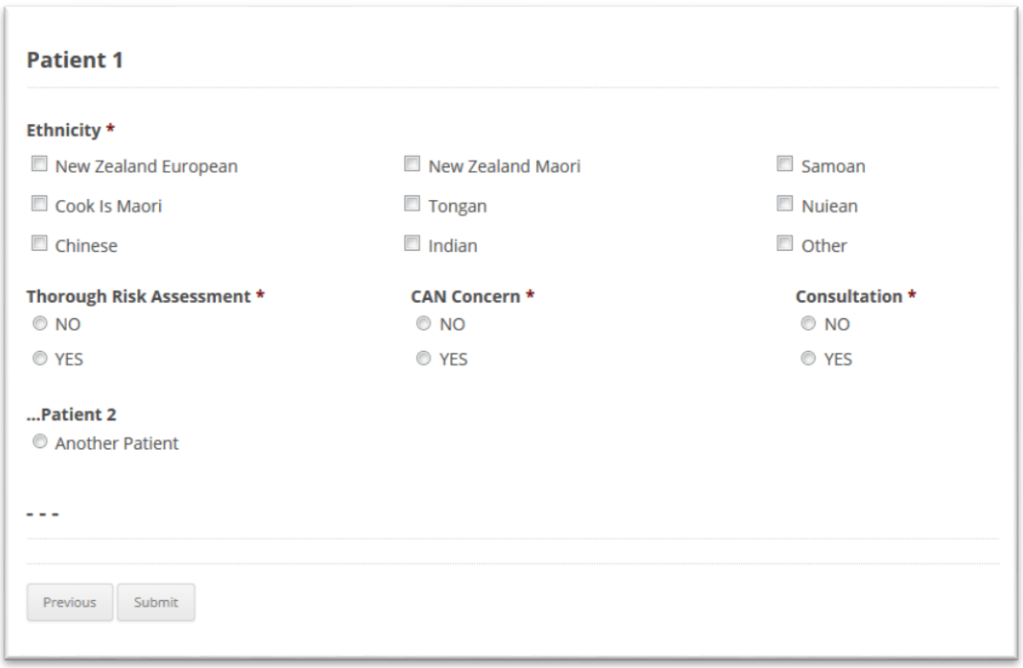
PA Referrals: Were appropriate referrals made?

NO	No identification in notes that referrals were discussed, or notes indicate referrals were made, but do not specify to whom, or appear incomplete.
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 information, facilitating immediate access to offsite services (e.g. Women's Refuge, community services).
YES: onsite	Immediate access to onsite support by a family violence specialist (such as a social worker, Women's Refuge advocate) who can provide victims with danger assessment, safety planning and who can facilitate access to office community **services.**

CHILD ABUSE & NEGLECT ASSESSMENT

- **Enter total number of all children under the age of 2 years presenting to ED for any reason during the audit period.**
- **From this number, randomly select 25.**





Risk Assessment: Was a thorough CAN assessment done?

NO	No evidence of a thorough CAN risk assessment (i.e. no Child Injury Flowchart or equivalent in notes, or Child Injury Flowchart is present but is blank, or is partially completed.)
YES	Evidence of thorough CAN risk assessment (i.e. Child Injury Flowchart or equivalent fully completed, including legible signature).

CAN Concern:	**Was a concern Identified?**
NO	No child protection concerns or risk factors of child abuse and neglect were documented; or documentation was not complete.
YES	A CAN concern (i.e. one or more risk factors) identified in the notes. If documentation of a Report of Concern, or suspected child maltreatment or child protection concern included in documentation, this would be 'YES'.

Consultation:	**Were identified concerns discussed?**
NO	No indication of discussion in the notes about 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 concerns, this is a 'NO'.
YES	Evidence that consultation occurred is in the notes with name and designation of person consulted. 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 risk factors, assessment of the level of risk and plan is recorded.

Please note:

1. **Data Entry for CAN Clinical Audit ED children under two – System getting stuck at Patient 19.**

Several DHBs are finding that they are getting stuck at patient 19 in the data entry process. Please "submit" your data at patient 19, and enter patient 20-25 in a different "batch". We will combine your data. Submitting your data is the only way to save your data.

2. **Know you've made an error and you've submitted the data.**

Please let us know and we can either correct the error or work out a solution with you.

3. **PA Child Health - System would not accept '0' for age of child under 1.**

Two options. Delete the '1' and type in '0' or use the arrow system to replace the '1' with a '0'. The system will accept a '0'.

APPENDIX D: DHB Self Audit Report: 120 Month Follow-up Form

Violence Intervention Programme (VIP) Evaluation

Self Audit Report: 120 Month Follow-up

**** District Health Board**

** Hospital(s)

** ** 2014

Attention: *Chief Executive Officer*
VIP Portfolio Manager
FVIC

Child Protection Coordinator

*Audit Team Leader, **** Email: Phone:

This 120 month follow-up report documents findings of a self audit conducted by the DHB Violence Intervention Programme for the period April 2013 to July 2014.

This information is provided to give DHBs information and guidance in developing and sustaining family violence prevention programmes in acute and community health services. It does not provide detailed evaluation information for programmes in primary care settings.[a]

In recognition of increasing programme maturity nationally, DHBs are being supported to complete self audit. The VIP audit process provides the opportunity for DHBs to build competence in the area of family violence prevention service delivery, as well as measuring progress over time. Procedures are conducted based on a philosophy of supporting programme leaders in building a culture of improvement.

An overall audit score and breakdown of scores across a series of categories is provided. Scores may range from 0 to 100, with higher numbers indicating greater system development. This report is kept confidential within the Ministry of Health VIP team. After completion of audits nationwide you will receive a report summarising finding. Programme scores for Partner Abuse and Child Abuse and Neglect programmes will be identified by DHB within the national report.

Independent evaluators will review all self audit documents and provide comments in a cover letter copied to the Ministry of Health VIP Programme Manager.

[a] A *Primary Health Care Family Violence Responsiveness Evaluation Tool* is available at www.aut.ac.nz/vipevaluation

***** DHB Violence Intervention Programme Self Audit Summary**

Violence Intervention Programme Coordinator Status

- **Family Violence Intervention Coordinator,** *FTE, permanent/fixed position, responsibility for PA/CAN/EAN, positions start/end date, reports to.*

- **Child Protection Coordinator,** *FTE, permanent/fixed position, responsibility for PA/CAN/EAN, positions start/end date, reports to.*

Additional VIP Positions

- *e.g. Admin Support, Elder Abuse Coordinator, *.*FTE, permanent/fixed position, reports to:*

Self Audit Findings and Observations

Overall audit scores over time are provided in Figure 1.

Attached to this report are also the following documents:

- Figure 2. Partner Abuse Programme Evaluation domain scores
- Figure 3. Child Abuse and Neglect Programmes Evaluation domain scores
- Audit Action Plan
- Whānau Ora and Training Initiatives Worksheet
- Clinical Audit Data and PDSA Worksheets

[Insert Figure . VIP Evaluation Scores Baseline (2003) – 120 Month Follow Up (2014)]

Most significant VIP achievements since the last audit:

Progress on Whānau Ora initiatives:

Programme Strengths:

Areas for improvement:

Recommendations:

Self Audit Report Approval:

DHB Violence Intervention Programme Audit Team Leader

_____	_____	_____
Name	**Signature**	**Review Date**

DHB Violence Intervention Programme Sponsor

_____	_____	_____
Name	**Signature**	**Review Date**

[Insert Figures of Partner Abuse and Child Abuse and Neglect Domain Scores]

Audit Action Plan: *Delete example topic and enter actions for your DHB*
Developed by:

Priority*	Area for Improvement	Corrective Action to be Taken	Completion Date	Responsibility	Resources Required
1	*Documentation form does not include the relationship of the alleged perpetrator.*	*Amend documentation form to include a space to record relationship of the alleged perpetrator.*	*30th Oct 2013.*	*Family Violence Intervention Coordinator*	*Time allocated to make amendment* *Sign off by Documentation Committee* *Sign off by manager*

*Priority ranking should be reflective of the impact on performance.

1. Whānau Ora Worksheet

1a. Please list VIP Whānau Ora actions taken since the last audit.

Funding Amount	Funding Source (VIP or other)	Initiative	Date	Partnerships	Outcome

1b. Please list VIP Whānau Ora actions planned for the next 12 months.

Funding Amount	Funding Source (VIP or other)	Initiative	Date	Partnerships	Outcome

1c.

Does your VIP strategic plan identify actions that you will take 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. National Training Package Worksheet

Sign Off Date	Please list any follow up contact (e.g., training observations, updates) with National Trainer since the last audit

2b National Training Package – Cultural Component

Sign Off Date	Please list who is involved in delivering the cultural component of the VIP Training since the last audit

3. Disability

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

CLINICAL AUDIT REPORTING
PLEASE ATTACH RELEVANT PDSA Worksheets

VIP Roll Out and Clinical Audit: Partner Abuse Screening

Service (note whether hospital in patient or community out patient service)	VIP Implemented (YES or NO) MoH Service Spec. Output 3.1		% of current staff who have received CORE training MoH Service Spec. Output 4.1 & 4.2					Most Recent Partner Abuse Screening Audit Refer QIA Toolkit		
	YES	NO	Doctor	Nurse	Midwife	Social Worker	Total	No. Eligible Records Reviewed	No. Screened	No. Disclosed
Emergency Department										
Child Health – In Patient								WILL BE COLLECTED IN SNAPSHOT AUDIT		
Child Health – Community										
Maternity – In Patient								WILL BE COLLECTED IN SNAPSHOT AUDIT		
Maternity – Community										
Sexual Health – Community										
Mental Health – In Patient										
Mental Health – Community										
Alcohol & Drug – Community										

Clinical Audit: Injury Assessment of Children Presenting to the Emergency Department
(Refer to QIA Toolkit: *Clinical audit of Violence Intervention Programme; Injury assessment of children presenting to the Emergency Department)*

	Review Period Start (dd/mm/yy)	Review Period End (dd/mm/yy)	No. Eligible Records Reviewed	No. Injury flow chart in notes	No. with appropriate referral (both discussion and plan documented)	Comments
Emergency Department	WILL BE COLLECTED IN SNAPSHOT AUDIT					

Clinical Audit: Documentation audit of referrals made by DHB to Child Youth and Family (CYF)
(Refer to QIA Toolkit: *Clinical audit of Violence Intervention Programme; CYF Referral Documentation Audit)*

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: 2014 Audit Round Process

[Letterhead removed]

VIP AUDIT PREPARATION INFORMATION
Self and Independent Audits
120 Month Follow-Up Evaluation, 2014

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 5 December 2014).

Audit Preparation
We encourage specification of a Self Audit Plan to guide 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). Additional self audit resources are available to assist you in effective self auditing. These include:

- Making an Audit Plan 2014
- Self Audit Plan Example
- Physical Environment Walk Through Form

Preparation 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.

Self audit indicator evidence:
- ❑ Collate evidence of all achieved indicators.
- ❑ Reference evidence location (such as policy title, date and page number) in the 'evidence' columns of the excel audit tools

Submitting Your Self Audit
Complete the following items:
- ❑ Partner Abuse excel audit tool
- ❑ Child Abuse and Programme Information Form (attached)
- ❑ Self Audit Report
- ❑ Please double-check all items have been answered
- ❑ Submit the above items to Annette Goodwin by your due date.

Independent Audit Preparation (on-site visit)
- ❑ Have indicator evidence (as prepared for the self audit) available for viewing by the independent evaluator
- ❑ Submit audit day itinerary (see below) and finalise with Annette Goodwin

Reporting

Self Audit Report. All DHBs are now required to submit a self audit report.

Independent Audit Report.

1. The VIP Portfolio Manager will receive a draft audit report approximately two weeks following the independent audit including child abuse and neglect, partner abuse and cultural responsiveness programme scores, self audit scores, audit summary, and recommendations.
2. Portfolio Managers are asked to provide feedback on draft report in two weeks. **NOTE:** Feedback should be limited to correcting errors in scoring or interpretation. DHB plans to act on audit recommendations should be included in VIP reporting to the Ministry of Health.
3. A final report encompassing feedback will be sent to DHB CEO, copied to portfolio managers, FVICs and MOH.

National Report. A national report and summary documenting VIP programme development across the audit periods will be made available in October 2014. 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.**

Audit Support

Audit support is available through various means. Regional FVICs should be the first point of contact. Please feel free to get help from the audit team to answer any outstanding questions. You may contact Annette Goodwin regarding document logistics or Christine McLean regarding audit tools.

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 Helen_Fraser@moh.govt.nz.

Research Team:

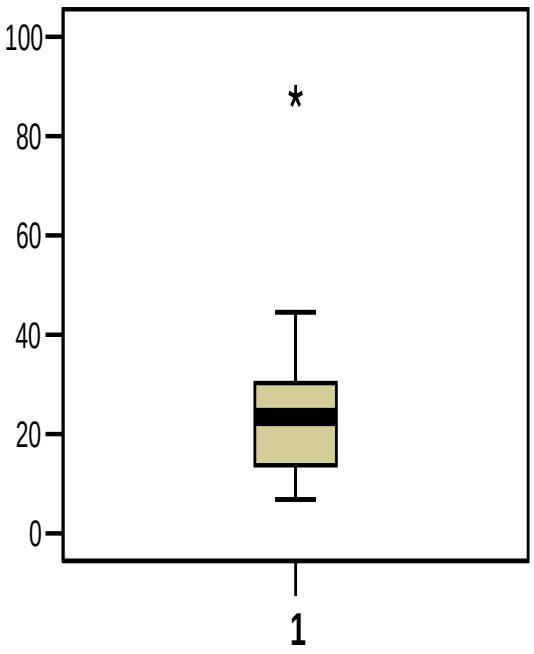
Independent audits will be conducted by Professor Jane Koziol-McLain, supported by Christine McLean.

Annette Goodwin
(09) 921 999 x 7153 agoodwin@aut.ac.nz

Christine McLean
(09) 921 9999 X 7114 cmclean@aut.ac.nz

Professor Jane Koziol-McLain, PhD, RN
(09) 921 9670 jkoziolm@aut.ac.nz

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 Scores									Achieving Target Score (≥70) n (%)								
	B	***F12***	***F30***	***F48***	***F60***	F84	***F96[c]***	***F108[d]***	***F120[e]***	***B***	***F12***	***F30[b]***	***F48***	***F60***	***F84***	***F96[c]***	***F108[d]/20***	***F120[d]/20***
Overall Score	19.6	27.6	49.2	66.9	74.4	84.4	91.3	92	**92**	1 (4%)	2 (8%)	5 (19%)	13[a] (48%)	15 (56%)	25 (93%)	27 (100%)	19 (95%)	**20 (100%)**
Domain Scores																		
Policies and Procedures	19.4	29.5	48.8	62.0	75.1	82.1	86.8	89.15	**87.2**	1 (4%)	2 (8%)	7 (26%)	11 (41%)	16 (59%)	20 (74%)	24 (89%)	18 (90%)	**19 (95%)**
Physical Environment	7.1	14.7	23.1	75.0	78.8	91.3	100	100	**100**	0 (0%)	1 (4%)	4 (15%)	16 (59%)	16 (59%)	23 (85%)	25 (93%)	18 (90%)	**19 (95%)**
Institutional Culture	22.1	30.7	59.0	72.4	83.4	88.9	93.7	97.24	**94.49**	2 (8%)	5 (20%)	8 (30%)	15 (56%)	16 (59%)	23 (85%)	25 (93%)	18 (90%)	**19 (95%)**
Training of Providers	10.9	31.9	58.7	78.2	88.4	89.1	100	100	**100**	1 (4%)	5 (20%)	8 (30%)	15 (56%)	18 (67%)	26 (96%)	26 (96%)	19 (95%)	**20 (100%)**
Screening and Safety Assessment	0.0	0.0	42.5	65.3	73.2	80.3	80.3	85.04	**86.61**	1 (4%)	2 (8%)	5 (19%)	13 (48%)	15 (56%)	18 (67%)	22 (82%)	17 (85%)	**20 (100%)**
Documentation	0.0	19.1	28.6	66.6	76.1	90.4	90.5	90.48	**100**	0 (0%)	0 (0%)	2 (7%)	12 (44%)	14 (52%)	22 (82%)	24 (89%)	18 (90%)	**18 (90%)**
Intervention Services	26.4	45.7	62.1	65.0	79.2	92.8	100	100	**97.14**	4 (16%)	6 (24%)	9 (33%)	11 (41%)	17 (63%)	24 (89%)	27 (100%)	20 (100%)	**20 (100%)**
Evaluation Activities	0.0	0.0	20.0	34.4	63.2	66.4	80.0	80.00	**90.00**	1 (4%)	1 (4%)	4 (15%)	6 (22%)	11 (41%)	13 (48%)	23 (85%)	14 (70%)	**15 (75%)**
Collaboration	37.5	77.1	78.5	93.0	91.6	100.0	100	100	**100**	1 (4%)	15 (60%)	19 (70%)	23 (85%)	25 (93%)	27 (100%)	27 (100%)	20 (100%)	**20 (100%)**

Notes: The unit of analysis changed from hospitals (n=27) to DHBs (n=20) for the 108 month follow-up audit; ***B*** =Baseline; ***F12*** =12 month follow-up; ***F30*** = 30 month follow-up; ***F48*** = 48 month follow-up; ***F60*** =60 month follow-up; ***F84*** = 84 month follow-up; ***F96*** =96 month follow-up; ***F108[c]*** = 108 month follow-up; 70 is selected benchmark score. [a] Includes one hospital score which was rounded up during analysis; [b] 30 month follow-up percentages corrected. [c] 96 month follow-up scores include independent scores (n=13 hospitals) and self audit scores (n=14 hospitals). [d]108 and [d]120 month follow-up scores include self audit scores (n=16) and independent audit scores (n=4).

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	96 mo FU Hospitals (%)	108 mo FU DHBs (%)	120 mo 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:	27 (100%)	19 (95%)	**20 (100%)**
	a) define partner abuse?	27 (100%)	20 (100%)	**20 (100%)**
	b) mandate training on partner abuse for any staff?	27 (100%)	20 (100%)	**19 (95%)**
	c) advocate universal screening for women anywhere in the hospital?	27 (100%)	20 (100%)	**20 (100%)**
	d) define who is responsible for screening?	27 (100%)	20 (100%)	**20 (100%)**
	e) address documentation?	27 (100%)	19 (95%)	**20 (100%)**
	f) address referral of victims?	27 (100%)	20 (100%)	**20 (100%)**
	g) address legal reporting requirements?	26 (96%)	19 (95%)	**20 (100%)**
	h) address the responsibilities to, and needs of, Māori?	27 (100%)	20 (100%)	**20 (100%)**
	i) address the needs of other (non-Māori/non-Pakeha) cultural and/or ethnic groups?	25 (93%)	19 (95%)	**20 (100%)**
	j) address the needs of LGBT clients?	24 (89%)	19 (95%)	**19 (95%)**
1.2	Is there evidence of a hospital-based partner abuse working group? If yes, does the group:	27 (100%)	20 (100%)	**19 (95%)**
	w	11 (41%)	11 (55%)	**13 (65%)**
	b) include representative(s) from more than two departments?	27 (100%)	20 (100%)	**19 (95%)**
	c) include representative(s) from the security department?	21 (78%)	15 (75%)	**16 (80%)**
	d) include physician(s) from the medical staff?	26 (96%)	17 (85%)	**17 (85%)**
	e) include representative(s) from a partner abuse advocacy organization (eg., Women's Refuge)?	25 (93%)	18 (90%)	**19 (95%)**
	f) include representative(s) from hospital administration?	27 (100%)	20 (100%)	**19 (95%)**
	g) include Māori representative(s)?	27 (100%)	20 (100%)	**19 (95%)**
1.3	Does the hospital provide direct financial support for the partner abuse programme (beyond VIP funding)?	21 (78%)	17 (85%)	**17 (85%**
1.3_a	Is funding set aside specifically for Māori programmes and initiatives?	15 (56%)	13 (65%)	**12 (60%)**
1.4	Is there a mandatory universal screening policy in place?	27 (100%)	20 (100%)	**20 (100%)**

	"YES" responses	96 mo FU Hospitals (%)	108 mo FU DHBs (%)	120 mo FU DHBs (%)
1.5	Are there quality assurance procedures in place to ensure partner abuse screening?	27 (100%)	19 (95%)	**20 (100%)**
	a) regular chart audits to assess screening?	26 (96%)	18 (90%)	**20 (100%)**
	b) positive reinforcers to promote screening?	25 (93%)	16 (80%)	**19 (95%)**
	c) is there regular supervision?	24 (89%)	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?	18 (67%)	17 (85%)	**19 (95%)**
	b) procedures that include name/phone block for victims admitted to hospital?	21 (78%)	17 (85%)	**16 (80%)**
	c) procedures that include provisions for safe transport from the hospital to shelter?	23 (85%)	17 (85%)	**18 (90%)**
	d) do these procedures take into account the needs of Māori?	14 (52%)	15 (75%)	**18 (90%)**
1.7	Is there an identifiable partner abuse coordinator at the hospital? If yes is it a: (*choose one*)	27 (100%)	20 (100%)	**20 (100%)**
	a) part time position or included with other responsibilities?	8 (30%)	6 (30%)	**6 (30%)**
	b) full-time position with no other responsibilities?	19 (70%)	14 (70%)	**14 (70%)**
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	3 (11%)	2 (10%)	**0 (0%)**
	21-35	24 (89%)	18 (90%)	**20 (100%)**
	In how many locations are there Māori images related to partner abuse on display? (up to 17):			
	1-10	0 (0%)	0 (0%)	**0 (0%)**
	11-17	27 (100%)	20 (100%)	**20% (100%**
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	3 (11%)	2 (10%)	**2 (10%)**
	21-35	24 (89%)	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	1 (4%)	3 (15%)	**4 (20%)**
	11-17	26 (96%)	17 (85%)	**16 (80%)**
	In how many locations is there referral information re non- Māori non-Pakeha on public display? (up to 17)			
	0-6	4 (16%)	4 (20%)	**5 (25%)**
	7-17	23 (84%)	16 (80%)	**15 (75%)**

	"YES" responses	96 mo FU Hospitals (%)	108 mo FU DHBs (%)	120 mo 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:	24 (89%)	20 (100%)	**20 (100%)**
	a) Does the design and use of the safe shelter support Māori cultural beliefs and practices?	22 (82%)	19 (95%)	**19 (95%)**
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	27 (100%)	20 (100%)	**19 (95%)**
	b) medical staff	24 (89%)	16 (80%)	**15 (75%)**
	c) administration	20 (74%)	16 (80%)	**16 (80%)**
	d) other staff/employees	27 (100%)	18 (90%)	**17 (85%)**
	If yes, did the assessment address staff knowledge and attitude about Māori and partner abuse?	25 (93%)	16 (80%)	**19 (95%)**
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	5 (19%)	0 (0%)	**0 (0%)**
	>48 months	22 (81 %)	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?	24 (89%)	17 (85%)	**18 (90%)**
	b) Does the Employee Assistance programme (or equivalent) maintain specific policies and procedures for dealing with employees experiencing partner abuse?	12 (44%)	15 (75%)	**16 (80%)**
	c) Is the topic of partner abuse among employees covered in the hospital training sessions and/or orientation?	27 (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?	27 (100%)	20 (100%)	**20 (100%)**
	b) Are cultural issues discussed in the hospital's partner abuse training programme?	27 (100%)	19 (95%)	**20 (100%)**
	c) Are translators/interpreters available for working with victims if English is not the victim's first language?	27 (100%)	19 (95%)	**20 (100%)**
	d) Are referral information and brochures related to partner abuse available in languages other than English?	27 (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*)	25 (93%)	19 (95%)	**19 (95%)**
	a) 1 programme in the last 12 months?	1 (4%)	2 (10%)	**3 (15%)**
	b) >1 programme in the last 12 months?	24 (89%)	17 (85%)	**16 (80%)**
	c) Does the hospital collaborate with Māori community organizations and providers to deliver preventive outreach and public education activities?	24 (89%)	18 (90%)	**16 (80%)**

	"YES" responses	96 mo FU Hospitals (%)	108 mo FU DHBs (%)	120 mo FU DHBs (%)
CATEGORY 4. TRAINING OF PROVIDERS				
4.1	Has a formal training plan been developed for the institution? If yes:	27 (100%)	19 (95%)	**20 (100%)**
	a) Does the plan include the provision of regular, ongoing education for clinical staff?	27 (100%)	19 (95%)	**20 (100%)**
	b) Does the plan include the provision of regular, ongoing education for non-clinical staff?	25 (93%)	18 (90%)	**17 (85%)**
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?	27 (100%)	20 (100%)	**19 (100%)**
	b) to members of the clinical staff via colloquia or other sessions?	27 (100%)	20 (100%)	**20 (100%)**
4.3	Does the hospital's training/education on partner abuse include information about:			
	a) definitions of partner abuse?	27 (100%)	19 (95%)	**20 (100%)**
	b) dynamics of partner abuse?	27 (100%)	19 (95%)	**20 (100%)**
	c) epidemiology?	27 (100%)	19 (95%)	**20 (100%)**
	d) health consequences?	27 (100%)	20 (100%)	**20 (100%)**
	e) strategies for screening?	27 (100%)	20 (100%)	**20 (100%)**
	f) risk assessment?	27 (100%)	20 (100%)	**20 (100%)**
	g) documentation?	27 (100%)	19 (95%)	**20 (100%)**
	h) intervention?	27 (100%)	20 (100%)	**20 (100%)**
	i) safety planning?	27 (100%)	20 (100%)	**20 (100%)**
	j) community resources?	27 (100%)	20 (100%)	**20 (100%)**
	k) reporting requirements?	27 (100%)	19 (95%)	**20 (100%)**
	l) legal issues?	27 (100%)	20 (100%)	**20 (100%)**
	m) confidentiality?	27 (100%)	19 (95%)	**20 (100%)**
	n) cultural competency?	27 (100%)	19 (95%)	**20 (100%)**
	o) clinical signs/symptoms?	27 (100%)	19 (95%)	**20 (100%)**
	p) Māori models of health?	27 (100%)	19 (95%)	**20 (100%)**
	q) risk assessment for children of victims?	27 (100%)	20 (100%)	**20 (100%)**
	r) social, cultural, historic, and economic context in which Māori family violence occurs?	27 (100%)	19 (95%)	**20 (100%)**
	s) te Tiriti o Waitangi?	27 (100%)	19 (95%)	**20 (100%)**
	t) Māori service providers and community resources?	27 (100%)	19 (95%)	**20 (100%)**
	u) service providers and community resources for ethnic and cultural groups other than Pakeha and Māori?	27 (100%)	19 (95%)	**20 (100%)**
	v) partner abuse in same-sex relationships?	27 (100%)	18 (90%)	**20 (100%)**
	w) service providers and community resources for victims of partner abuse who are in same-sex relationships?	26 (96%)	18 (90%)	**20 (100%)**

	"YES" responses	96 mo FU Hospitals (%)	108 mo FU DHBs (%)	120 mo FU DHBs (%)
4.4	Is the partner abuse training provided by: (*choose one a-c and answer d-e*)			
	a) a single individual?	1 (4%)	1 (5%)	**0 (0%)**
	b) a team of hospital employees only?	0(0%)	0 (0%)	**0 (0%)**
	c) a team, including community expert(s)?	26 (96%)	19 (95%)	**20 (100%)**
	If provided by a team, does it include:			
	d) a Māori representative?	26 (96%)	19 (95%)	**19 (95%)**
	e) a representative(s) of other ethnic/cultural groups?	23 (85%)	16 (80%)	**14 (70%)**
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	27 (100%)	19 (95%)	**20 (100%**
	a) included, as a separate form, in the clinical record?	1 (4%)	0 (0%)	**0 (9%)**
	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?	17 (63%)	7 (35%)	**7 (35%)**
	d) incorporated as questions in clinical record for all charts in out-patient and in-patient areas?	9 (33%)	12 (60%)	**13 (65%)**
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	0 (0%)	1 (5%)	**0 (0%)**
	0% - 10%	5 (18%)	4 (20%)	**0 (0%)**
	11% - 25%	2 (8%)	1 (5%)	**2 ((10%)**
	26% - 50%	11 (41%)	5 (25%)	**8 (40%)**
	51% - 75%	6 (22%)	5 (25%)	**8 (40%)**
	76% - 100%	3 (11%)	4 (20%)	**2 (10%)**
5.3	Is a standardized safety assessment performed and discussed with victims who screen positive for partner abuse? If yes, does this:	27 (100%)	18 (90%)	**20 (100%)**
	a) also assess the safety of any children in the victim's care?	27 (100%)	18 (90%)	**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:	26 (96%)	19 (95%)	**20 (100%)**
	a) information on the results of partner abuse screening?	26 (96%)	19 (95%)	**20 (100%)**
	b) the victim's description of current and/or past abuse?	24 (89%)	19 (95%)	**19 (95%)**
	c) the name of the alleged perpetrator and relationship to the victim?	24 (89%)	19 (95%)	**20 (100%)**
	d) a body map to document injuries?	23 (85%)	18 (90%)	**19 (95%)**
	e) information documenting the referrals provided to the victim?	26 (96%)	19 (95%)	**20 (100%)**
	f) in the case of Māori, information documenting whether the individual was offered a Māori advocate?	25 (93%)	19 (95%)	**20 (100%)**

	"YES" responses	96 mo FU Hospitals (%)	108 mo FU DHBs (%)	120 mo 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?	25 (93%)	19 (90%)	**20 (100%)**
	b) Do hospital staff receive on-going training on the use of the camera?	18 (67%)	13 (65%)	**16 (80%)**
	c) Do hospital staff routinely offer to photograph all abused patients with injuries?	16 (59%)	13 (65%)	**16 (80%)**
	d) Is a specific, unique consent-to-photograph form obtained prior to photographing any injuries?	21 (78%)	16 (80%)	**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?	17 (63%)	16 (80%)	**16 (80%)**
CATEGORY 7. INTERVENTION SERVICES				
7.1	Is there a standard intervention checklist for staff to use/refer to when victims are identified?	27 (100%)	19 (100%)	**20 (100%)**
7.2	Are on-site victim advocacy services provided? If yes, *choose one a-b and answer c-d)*:	27 (100%)	20 (100%	**20 (100%)**
	a) A trained victim advocate provides services during certain hours.	4 (15%)	2 (10%)	**2 (10%)**
	b) A trained victim advocate provides service at all times.	23 (85%)	18 (90%)	**18 (95%**
	c) is a Māori advocate is available on-site for Māori victims?	27 (100%)	20 (100%)	**19 (100%)**
	d) is an advocate(s) of ethnic and cultural background other than Pakeha and Māori available onsite?	26 (96%)	19 (95%)	**18 (90%)**
7.3	Are mental health/psychological assessments performed within the context of the programme? If yes, are they:	27 (100%)	20 (100%)	**20 (100%)**
	a) available, when indicated?	4 (15%)	8 (40%)	**7 (35%)**
	b) performed routinely?	23 (85%)	12 (60%)	**13 (65%)**
7.4	Is transportation provided for victims, if needed?	24 (89%)	20 (100%)	**19 (95%)**
7.5	Does the hospital partner abuse programme include follow-up contact and counselling with victims after the initial assessment?	26 (96%)	19 (95%)	**18 (90%)**
7.6	Does the hospital partner abuse programme offer and provide on-site legal options counselling for victims?	27 (100%)	20 (100%)	**19 (95%)**
7.7	Does the hospital partner abuse programme offer and provide partner abuse services for the children of victims?	27 (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?	27 (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:	26 (96%)	19 (95%)	**20 (100%)**
	a) Do evaluation activities include periodic monitoring of charts to audit for partner abuse screening?	27 (100%)	18 (90%)	**20 (100%)**
	b) Do evaluation activities include peer-to-peer case reviews around partner abuse?	26 (96%)	18 (90%)	**20 (100%)**
8.2	Do health care providers receive standardized feedback on their performance and on patients?	22 (82%)	15 (75%)	**18 (90%)**
8.3	Is there any measurement of client satisfaction and/or community satisfaction with the partner abuse programme?	21 (78%)	16 (80%)	**15 (75%)**
8.4	Is a quality framework (such as Whānau Ora) used to evaluate whether services are effective for Māori?	10 (37%)	9 (45%)	**10 (50%)**

	"YES" responses	96 mo FU Hospitals (%)	108 mo FU DHBs (%)	120 mo FU DHBs (%)
CATEGORY 9. COLLABORATION				
9.1	Does the hospital collaborate with local partner abuse programmes? If yes,	27 (100%)	20 (100%)	**20 (100%)**
	a i) collaboration with training?	26 (96%)	19 (95%)	**20 (100%)**
	ii) collaboration on policy and procedure development?	27 (100%)	20 (100%)	**20 (100%)**
	iii) collaboration on partner abuse working group?	25 (93%)	19 (95%)	**20 (100%)**
	iv) collaboration on site service provision?	27 (100%)	20 (100%)	**20 (100%)**
	b) is collaboration with			
	i) Māori provider(s) or representative(s)?	27 (100%)	20 (100%)	**20 (100%)**
	ii) Provider(s) or representative(s) for ethnic or cultural groups other than Pakeha or Māori?	25 (93%)	18 (90%)	**19 (95%)**
9.2	Does the hospital collaborate with local police and courts in conjunction with their partner abuse programme? If yes:	27 (100%)	20 (100%)	**20 (100%**
	a) collaboration with training?	26 (96%)	19 (95%)	**20 (100%)**
	b) collaboration on policy and procedure development?	27 (100%)	20 (100%)	**20 (100%)**
	c) collaboration on partner abuse working group?	25 (93%)	19 (95%)	**20 (100%)**
9.3	Is there collaboration with the partner abuse programme of other health care facilities? If yes, which types of collaboration apply:	27 (100%)	20 (100%)	**20 (100%)**
	a) within the same health care system?	27 (100%)	20 (100%)	**20 (100%)**
	If yes, with a Māori health unit?	26 (96%)	20 (100%)	**19 (100%)**
	b) with other systems in the region?	27 (100%)	20 (100%)	**20 (100%)**
	If yes, with a Māori health provider?	26 (96%)	19 (95%)	**18 (90%)**

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

	Median									Achieving Target Score ≥70								
	B	***F12***	***F30***	***F48***[a]	***F60***	***F84***	***F96***[c]	***F108***[d]	***F120***[d]	***B***	***F12***	***F30***[b]	***F48***[a]	***F60***	***F84***	***F96***[c]	***F108***[d]***/20***	***F120***[d]***/20***
Overall Score	36.7	50.8	59.3	74.5	80.9	86.5	90.8	92.3	**92.9**	2 (8%)	3 (12%)	4 (15%)	17 (65%)	21 (78%)	25 (93%)	27 (100%)	19 (95%)	**20 (100%)**
Domain Scores																		
Policies and Procedures	42.5	50.0	59.7	81.0	84.0	92.0	95.0	95.0	**95.5**	3 (12%)	5 (20%)	8 (29%)	23 (89%)	19 (70%)	26 (96%)	27 (100%)	20 (100%)	**20 (100%)**
Safety & Security	-	-	-	77.0	72.0	82.0	90.0	92.0	**96.0**	-	-	-	17 (65%)	17 (63%)	23 (85%)	27 (100%)	19 (95%)	**20 (100%)**
Collaboration	46.5	70.8	85.4	82.5	91.0	94.0	97.0	98.0	**100**	5 (20%)	15 (60%)	20 (74%)	21 (81%)	25 (93%)	26 (96%)	27 (100%)	20 (100%)	**20 (100%)**
Institutional Culture	41.5	43.4	56.6	80.0	82.0	86.0	90.0	94.0	**96.0**	3 (12%)	5 (20%)	6 (22%)	18 (69%)	20 (74%)	25 (93%)	27 (100%)	20 (100%)	**20 (100%)**
Training of Providers	39.7	49.4	66.7	92.5	96.0	98.0	100	100	**100**	2 (8%)	9 (36%)	14 (52%)	19 (73%)	22 (82%)	26 (96%)	27 (100%)	20 (100%)	**20 (100%)**
Intervention Services	65.4	70.4	72.8	82.0	84.0	89.0	92.0	89.0	**88.5**	12 (48%)	13 (52%)	15 (56%)	21 (81%)	22 (82%)	27 (100%)	27 (100%)	20 (100%)	**20 (100%)**
Documentation	19.0	28.6	58.4	83.5	83.0	87.0	93.0	95.5	**97**	5 (20%)	5 (20%)	8 (29%)	22 (85%)	19 (70%)	22 (82%)	24 (89%)	19 (95%)	**19 (95%)**
Evaluation Activities	35.1	36.6	36.6	29.8	58.5	72.0	75.5	72.75	**79.5**	1 (4%)	1 (4%)	5 19%)	3 (12%)	7 (26%)	14 (52%)	18 (67%)	11 (55%)	**15 (75%)**
Physical Environment	23.0	28.0	35.6	68.0	91.0	100	100	100	**100**	1 (4%)	2 (5%)	2 7%)	12 46%)	26 (96%)	27 (100%)	27 (100%)	19 (95%)	**20 (100%)**

Notes: The unit of analysis changed from hospitals (n=27) to DHBs (n=20) for the 108 month follow-up audit; ***B*** =Baseline; ***F12*** =12 month follow-up; ***F30*** = 30 month follow-up; ***F48*** = 48 month follow-up; ***F60*** = 60 month follow-up; ***F84*** = 84 month follow-up; ***F96*** =96 month follow-up; ***F108*** =108 month follow-up; 70 is selected benchmark score; [a] Change to Revised Delphi tool; [b] 30 month follow-up percentages corrected; [c] change to imputing self audit scores - 96 month follow-up scores include independent scores (n=13 hospitals) and self audit scores (n=14 hospitals). [d] 108 and [d]120 month follow-up scores include self audit scores (n=16) and independent audit scores (n=4).

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	96 mo FU Hospitals (%)	108 mo FU DHBs (%)	120 mo 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:	27 (100%)	20 (100%)	**20 (100%)**
	a) Define child abuse and neglect?	27 (100%)	20 (100%)	**20 (100%)**
	b) Mandate training on child abuse and neglect for staff?	25 (93%)	20 (100%)	**20 (100%)**
	c) Outline age-appropriate protocols for risk assessment?	23 (85%)	18 (90%)	**19 (95%)**
	d) Define who is responsible for risk assessment?	27 (100%)	19 (95%)	**20 (100%)**
	e) Address the issue of contamination during interviewing?	24 (89%)	19 (95%)	**20 (100%)**
	f) Address documentation?	27 (100%)	19 (95%)	**20 (100%)**
	g) Address referrals for children and their families?	27 (100%)	19 (95%)	**20 (100%)**
	h) Address child protection reporting requirements?	27 (100%)	18 (90%)	**20 (100%)**
	i) Address the responsibilities to, and needs of, Māori?	27 (100%)	20 (100%)	**20 (100%)**
	j) Address other cultural and/or ethnic groups?	26 (96%)	20 (100%)	**20 (100%)**
1.2	Who is consulted regarding child protection policies and procedures?			50
	Māori and Pacific?	27 (100%)	20 (100%)	**20 (100%)**
	CYF?	27 (100%)	19 (95%)	**20 (100%)**
	Police?	27 (100%)	18 (90%)	**20 (100%)**
	Child abuse and neglect programme and Violence Intervention Programme staff?	27 (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)	27 (100%)	18 (90%)	**19 (95%)**
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?	26 (97%)	19 (95%)	**19 (95%)**
	b) Include representatives from more than two departments?	27 (100%)	19 (95%)	**19 (95%)**

	"YES" responses	96 mo FU Hospitals (%)	108 mo FU DHBs (%)	120 mo FU DHBs (%)
1.4	Does the DHB provide direct financial support for the child abuse and neglect programme (beyond VIP funding)?	24 (89%)	20 (100%)	**20 (100%)**
	a) Is funding set aside specifically for Māori programmes and initiatives?	19 (70%)	15 (75%)	**11 (55%)**
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?	27 (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?	27 (100%)	19 (95%)	**20 (100%)**
	b) include name/phone block?	21 (78%)	16 (80%)	**18 (90%)**
	c) provide for safe transportation?	20 (74%)	16 (80%)	**19 (95%)**
	d) account for the needs of Māori?	23 (85%)	17 (85%)	**19 (95%)**
1.7	Is there an identifiable child protection coordinator at the DHB? If yes, is the coordinator position (choose one):	27 (100%)	20 (100%)	**20 (100%)**
	a) part-time <0.5 FTE	1 (4%)	2 (10%)	**1 (5%)**
	b) part-time ≥0.5 FTE?	8 (29%)	4 (20%)	**6 (30%)**
	c) full-time?	18 (67%)	14 (70%)	**13 (65%)**
1.8	Are there policies that outline the minimum expectation for all staff:			
	a) to attend mandatory training?	25 (93%)	20 (100%)	**20 (100%)**
	b) to identification and referral children at risk?	27 (100%)	20 (100%)	**20 (100%)**
	c) to reporting child protection concerns?	27 (100%)	19 (95%)	**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?	27 (100%)	20 (100%)	**20 (100%)**
	b) community groups?	27 (100%)	20 (100%)	**20 (100%)**
1.10	Are the DHB policies and procedures easily accessible and user-friendly? If yes, are	27 (100%)	20 (100%)	
	a) they available on the DHB intranet?	27 (100%)	20 (100%)	**19 (95%)**
	b) there supporting and reference documents appended to the appropriate policies and procedures?	27 (100%)	20 (100%)	**20 (100%)**
	c) there translation materials to facilitate the application of policy and procedures, such as flowcharts and algorithms?	27 (100%)	19 (95%)	**20 (100%)**
1.11	Are the DHB policies and procedures cross-referenced to other forms of family violence, such as partner abuse and elder abuse?	26 (96%)	20 (100%)	**20 (100%)**

	"YES" responses	96 mo FU Hospitals (%)	108 mo FU DHBs (%)	120 mo 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?	27 (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:	27 (100%)	19 (95%)	**19 (95%)**
	b) within the DHB?	27 (100%)	20 (100%)	**20 (100%)**
	c) with other groups and agencies in the region?	27 (100%)	19 (95%)	**20 (100%)**
	d) with Māori and Pacific health providers?	27 (100%)	20 (100%)	**20 (100%)**
	e) with other relevant ethnic/cultural groups?	24 (89%)	17 (85%)	**18 (90%)**
	f) with the primary health sector?	21 (78%)	19 (95%)	**18 (90%)**
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?	27 (100%)	20 (100%)	**20 (100%)**
	b) with relevant primary health care providers as part of discharge planning?	19 (70%)	19 (95%)	**20 (100%)**
	c) by accessing necessary support services for the child and family to promote ongoing safety of the child?	27 (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?	27 (100%)	19 (95%)	**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	24 (89%)	19 (95%)	**18 (90%)**
	c) a local alert system in community setting, including PHO	6 (22%)	9 (45%)	**15 (75%)**
	d) a process for notification of alert placements to relevant providers	15 (56%)	14 (70%)	**18 (90%)**
	e) participation in a national alert system (108 Mo. note 8 NCPAS approved + 3 self-reporting that in process)	13 (48%)	11 (55%)	**15 (75%)**
	f) clear criteria for identifying levels of risk, and process that guides the use of the alert system	18 (67%)	13 (65%)	**17 (85%)**
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?	26 (96%)	19 (95%)	**20 (100%)**
	b) process for notifying CYF and/or other agencies?	26 (96%)	19 (95%)	**20 (100%)**
	c) referral form that requires the documentation of the risk assessed for these children?	19 (70.4%)	18 (90%)	**20 (100%)**

	"YES" responses	96 mo FU Hospitals (%)	108 mo FU DHBs (%)	120 mo FU DHBs (%)
	CATEGORY 3. COLLABORATION			
3.1	Does the DHB collaborate with CYF and NGO child advocacy and protection?	27 (100%)	20 (100%)	**20 (100%)**
	a) which types of collaboration apply:			
	i) collaboration with training?	27 (100%)	20 (100%)	**20 (100%)**
	ii) collaboration on policy and procedure development?	27 (100%)	20 (100%)	**20 (100%)**
	iii) collaboration on child abuse and neglect task force?	27 (100%)	19 (95%)	**20 (100%)**
	iv) collaboration on site service provision?	27 (100%)	19 (95%)	**20 (100%)**
	v) collaboration is two-way?	27 (100%)	20 (100%)	**20 (100%)**
	b) is collaboration with:			
	i) CYF?	27 (100%)	20 (100%)	**20 (100%)**
	ii) NGOs and other agencies such as Women's Refuge?	27 (100%)	20 (100%)	**20 (100%)**
	iii) Māori provider(s) or representative(s)?	27 (100%)	20 (100%)	**20 (100%)**
	iv) Provider(s) or representative(s) for ethnic or cultural groups other than Pakeha or Māori?	27 (100%)	18 (90%)	**18 (90%)**
	c) services, departments and between relevant staff within the DHB evident?	27 (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:	27 (100%)	20 (100%)	**20 (100%)**
	a) collaboration with training?	27 (100%)	20 (100%)	**20 (100%)**
	b) collaboration on policy and procedure development?	27 (100%)	20 (100%)	**20 (100%)**
	c) collaboration on child abuse and neglect task force?	27 (100%)	19 (95%)	**19 (95%)**
3.3	Is there collaboration of the child abuse and neglect programme with other health care facilities? If yes, which types of collaboration apply:	27 (100%)	20 (100%)	**20 (100%)**
	a) within the DHB?	27 (100%)	20 (100%)	**20 (100%)**
	b) with a Māori unit?	27 (100%)	20 (100%)	**20 (100%)**
	c) with other groups and agencies in the region?	27 (100%)	20 (100%)	**20 (100%)**
	d) with a Māori health provider?	25 (93%)	19 (95%)	**20 (100%)**
	e) with the primary health care sector?	27 (100%)	20 (100%)	**19 (95%)**
	f) with national network of child protection and family violence coordinators?	27 (100%)	20 (100%)	**20 (100%)**

	"YES" responses	96 mo FU Hospitals (%)	108 mo FU DHBs (%)	120 mo FU DHBs (%)
3.4	Do relevant staff have membership on, or attend:			
	a) the interdisciplinary child protection team?	27 (100%)	20 (100%)	**20 (100%)**
	b) Child abuse team meetings?	27 (100%)	20 (100%)	**20 (100%)**
	c) Sexual abuse team meetings?	26 (96%)	18 (90%)	**17 (85%)**
	d) CYF Care and Protection Resource Panel?	25 (93%)	17 (85%)	**18 (90%)**
	e) National Network of Family Violence Intervention Coordinators?	27 (100%)	20 (100%)	**20 (100%)**
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?	25 (93%)	20 (100%)	**20 (100%)**
	b) the Police?	25 (93%)	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?	23 (85%)	18 (90%)	**19 (95%)**
	b) Police?	23 (85%)	18 (90%)	**19 (95%)**
	c) DSAC?	18 (67%)	17 (85%)	**17 (85%)**
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?	21 (78%)	15 (75%)	**18 (90%)**
	b) child protection is in the DHB Annual Plan?	26 (96%)	16 (80%)	**20 (100%)**
	c) the child protection programme is adequately resourced, including dedicated programme staff?	19 (70%)	16 (80%)	**18 (90%)**
	d) a working group of skilled and trained people who operationalises policies and procedures, in addition to the child protection coordinator?	27 (100%)	20 (100%)	**20 (100%)**
	e) attendance at training as a key performance indicator (KPI) for staff?	16 (59%)	13 (65%)	**13 (65%)**
	f) roles of those in the child abuse and neglect working team are included in position descriptions?	14 (52%)	15 (75%)	**18 (90%)**
	g) DHB representation on the CYF Care and Protection Resource Panel?	25 (93%)	17 (85%)	**19 (95%)**
	h) the Child Protection Coordinator is supported to attend the VIP Coordinator Meetings?	27 (100%)	20 (100%)	**20 (100%)**

	"YES" responses	96 mo FU Hospitals (%)	108 mo FU DHBs (%)	120 mo 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?	27 (100%)	20 (100%	**19 (95%)**
	a) nursing staff	27 (100%)	20 (100%)	**19 (95%)**
	b) medical staff	24 (89%)	18 (90%)	**16 (80%)**
	c) administration	18 (67%)	15 (75%)	**14 (70%)**
	d) other staff/employees	25 (93%)	18 (90%)	**19 (95%)**
	If yes, did the assessment address staff knowledge and attitude about Māori and child abuse and neglect?	23 (85%)	17 (85%)	**19 (95%)**
4.3	How long has the hospital's child abuse and neglect programme been in existence?			
	a) 24-48 months	1 (4%)		
	b) >48 months	26 (96%)	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?	27 (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?	27 (100%)	20 (100%)	**20 (100%)**
	c) Are cultural issues discussed in the hospital's child abuse and neglect training programme?	25 (93%)	20 (100%)	**20 (100%)**
	d) are translators/interpreters available for working with victims if English is not the victim's first language?	27 (100%)	20 (100%)	**20 (100%)**
	e) Are referral information and brochures related to child abuse and neglect available in languages other than English?	23 (85%)	16 (80%)	**17 (85%)**
4.5	Does the DHB participate in prevention outreach/public education activities on the topic of child abuse and neglect?	27 (100%)	20 (100%)	**20 (100%)**
	a) 1 programme in the last 12 months?	1 (4%)	2 (10%)	**3 (15%)**
	b) >1 programme in the last 12 months?	26 (96%)	18 (90%)	**17 (85%)**
	c) Does the DHB collaborate with Māori community organisations and providers to deliver preventive outreach and public education activities?	19 (70%)	17 (85%)	**18 (90%)**
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?	25 (93%)	20 (100%)	**19 (95%)**
	a) is a list of supportive interventions available?	27 (100%)	20 (100%)	**20 (100%)**
	b) are staff aware of how to access support and interventions available?	27 (100%)	20 (100%)	**20 (100%)**

	"YES" responses	96 mo FU Hospitals (%)	108 mo FU DHBs (%)	120 mo FU DHBs (%)
4.7	Is there evidence of coordination between the DHB child abuse and neglect programme in collaboration with other violence intervention programmes?	27 (100%)	19 (95%)	**20 (100%)**
	a) is there is a referral mechanism?	27 (100%)	20 (100%)	**20 (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?	25 (93%)	20 (100%)	**20 (100%)**
	b) a list of translators is accessible?	26 (96%)	20 (100%)	**20 (100%)**
	c) translators used that are gender and age appropriate?	18 (67%)	15 (75%)	**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?	26 (96%)	20 (100%)	**18 (90%)**
	b) access to child abuse and neglect training?	26 (96%)	19 (95%)	**19 (95%)**
	c) coordination of referral processes between the DHB and primary health care sectors?	20 (74%)	17 (85%)	**18 (90%)**
	d) ongoing relationships and activities that focus on prevention and promoting child protection?	25 (93%)	20 (100%)	**19 (95%)**
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?	26 (96%)	19 (95%)	**20 (100%)**
	b) an operational plan that outlines the specifics of the programme of training?	27 (100%)	19 (95%)	**20 (100%)**
	c) Does the plan include the provision of regular, ongoing education for clinical staff?	27 (100%)	19 (95%)	**20 (100%)**
	d) Does the plan include the provision of regular, ongoing education for non-clinical staff?	25 (93%)	19 (95%)	**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?	27 (100%)	19 (95%)	**19 (95%)**
	b) to members of the clinical staff via colloquia or other sessions?	27 (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?	27 (100%)	20 (100%)	**20 (100%)**
	b) dynamics of child abuse and neglect?	27 (100%)	20 (100%)	**20 (100%)**
	c) child advocacy?	27 (100%)	20 (100%)	**20 (100%)**
	d) appropriate child-centred interviewing?	26 (96%)	20 (100%)	**20 (100%)**
	e) issues of contamination?	27 (100%)	20 (100%)	**20 (100%)**
	f) ethical dilemmas?	27 (100%)	20 (100%)	**20 (100%)**

	"YES" responses	96 mo FU Hospitals (%)	108 mo FU DHBs (%)	120 mo FU DHBs (%)
	g) conflict of interest?	27 (100%)	20 (100%)	**20 (100%)**
	h) epidemiology?	27 (100%)	20 (100%)	**20 (100%)**
	i) health consequences?	25 (93%)	20 (100%)	**20 (100%)**
	j) identifying high risk indicators?	27 (100%)	20 (100%)	**20 (100%)**
	k) physical signs and symptoms?	27 (100%)	20 (100%)	**20 (100%)**
	l) dual assessment with partner violence?	27 (100%)	19 (100%)	**20 (100%)**
	m) documentation?	27 (100%)	20 (100%)	**20 (100%)**
	n) intervention?	27 (100%)	20 (100%)	**20 (100%)**
	o) safety planning?	27 (100%)	20 (100%)	**20 (100%)**
	p) community resources?	27 (100%)	20 (100%)	**20 (100%)**
	q) child protection reporting requirements?	27 (100%)	20 (100%)	**20 (100%)**
	r) linking with the police and child youth and family?	27 (100%)	20 (100%)	**20 (100%)**
	s) limits of confidentiality?	27 (100%)	20 (100%)	**20 (100%)**
	t) age appropriate assessment and intervention?	27 (100%)	19 (95%)	**20 (100%)**
	u) cultural issues?	27 (100%)	20 (100%)	**20 (100%)**
	v) link between partner violence and child abuse and neglect?	27 (100%)	20 (100%)	**20 (100%)**
	w) Māori models of health?	24 (89%)	19 (95%))	**19 (95%)**
	x) the social, cultural, historic, and economic context in which Māori family violence occurs?	23 (85%)	18 (90%)	**19 (95%)**
	y) Te Tiriti o Waitangi?	26 (96%)	20 (100%)	**20 (100%)**
	z) Māori service providers and community resources?	27 (100%)	20 (100%)	**20 (100%)**
	aa) service providers and community resources for ethic and cultural groups other than Pakeha and Māori?	27 (100%)	19 (100%)	**18 (90%)**
	ab) If all sub-items are evident, bonus 1.5	20 (74%)	16 (80%)	**18 (90%)**
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?	0 (0%)	1 (5%)	**0 (0%)**
	d) a team, including community expert(s)?	27 (100%)	19 (95%)	**20 (100%)**
	e) a Child Youth and Family statutory social worker?	27 (100%)	19 (95%)	**20 (100%)**
	f) a Māori representative?	26 (96%)	19 (95%)	**18 (90%)**
	g) a representative(s) of other ethnic/cultural groups?	22 (82%)	13 (65%)	**12 (60%)**

	"YES" responses	96 mo FU Hospitals (%)	108 mo FU DHBs (%)	120 mo 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?	27 (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?	27 (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?	27 (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*:	27 (100%)	20 (100%)	
	a) A member of the child protection team or social worker provides services during certain hours.	3 (11%)	5 (25%)	**8 (40%)**
	b) A member of the child protection team or social worker provides service at all times.	24 (89%)	15 (75%)	**12 (60%)**
	c) A Māori advocate or social worker is available "on-site" for Māori victims.	26 (96%)	19 (95%)	**19 (95%)**
	d) An advocate of ethnic and cultural background other Pakeha and Māori is available onsite.	23 (85%)	16 (80%)	**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*)	27 (100%)	20 (100%)	**20 (100%)**
	a) available, when indicated?	11 (41%)	12 (60%)	**11 (55%)**
	b) performed routinely?	16 (59%)	8 (40%)	**9 (45%)**
	c) age-appropriate?	27 (100%)	20 (100%)	**20 (100%)**
6.4	Do the intervention services include:			
	a) access to physical and sexual examination?	27 (100%)	20 (100%)	**20 (100%)**
	b) access to specialised sexual abuse services?	27 (100%)	20 (100%)	**20 (100%)**
	c) family focused interventions?	27 (100%)	19 (100%)	**20 (100%)**
	d) support services that include relevant NGOs, or acute crisis counsellors/support?	27 (100%)	19 (95%)	**20 (100%)**
	e) culturally appropriate advocacy and support?	27 (100%)	19 (95%)	**20 (100%)**
6.5	Are Social Workers available?			
	a) Monday to Friday 8 am to 4 pm service, with referrals outside of these hours?	16 (59%)	12 (60%)	**11 (55%)**
	b) 0n-call after 4 pm and at weekends?	3 (11%)	3 (15%)	**2 (10%)**
	c) as a 24 hour service?	8 (30%)	5 (25%)	**7 (35%)**
6.6	Is there a current list of relevant services available to support child and family safety?	27 (100%)	20 (100%)	**20 (100%)**
6.7	Is provision made for transport for victims and their families, if needed?	24 (89%)	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?	27 (100%)	20 (100%)	**20 (100%)**

	"YES" responses	96 mo FU Hospitals (%)	108 mo FU DHBs (%)	120 mo 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	26 (96%)	20 (100%)	**20 (100%)**
	b) siblings	26 (96%)	19 (95%)	**20 (100%)**
6.10	Is there evidence of coordination with CYF and the Police for children identified at risk of child abuse and neglect?	27 (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:	26 (96%)		**20 (100%)**
	a) Reason for presentation?	26 (96%)	19 (95%)	**20 (100%)**
	b) information generated by risk assessment?	25 (93%)	18 (90%)	**19 (100%)**
	c) the victim or caregiver's description of current and/or past abuse?	26 (96%)	19 (95%)	**20 (100%)**
	d) the name of the alleged perpetrator and relationship to the victim?	21 (78%)	16 (80%)	**18 (90%)**
	e) a body map to document injuries?	25 (93%)	19 (95%)	**20 (100%)**
	f) Past medical history?	22 (82%)	18 (90%)	**20 (100%)**
	g) A social history, including living circumstances?	24 (89%)	18 (90%)	**20 (100%)**
	h) An injury assessment, including photographic evidence (if appropriate)?	23 (85%)	17 (85%)	**20 (100%)**
	i) The interventions undertaken?	23 (85%)	18 (90%)	**19 (95%)**
	j) information documenting the referrals provided to the victim and their family?	21 (78%)	19 (95%)	**20 (100%)**
	k) in the case of Māori, information documenting whether the victim and their family were offered a Māori advocate?	19 (70%)	14 (70%)	**16 (80%)**
7.2	Does the DHB have sexual abuse specific forms that include:			
	a) a genital diagram?	24 (89%)	19 (95%)	**18 (90%)**
	b) a consent form?	23 (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:	27 (100%)	20 (100%)	
	a) CYF notification?	27 (100%)	20 (100%)	**20 (100%)**
	b) Police notification?	19 (70%)	15 (75%)	**14 (70%)**
7.4	Are staff provided training on documentation for children regarding abuse and neglect?	27 (100%)	20 (100%)	**20 (100%)**

	"YES" responses	96 mo FU Hospitals (%)	108 mo FU DHBs (%)	120 mo 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?	26 (96%)	20 (100%)	**20 (100%)**
	b) Is the evaluation process standardised?	25 (93%)	17 (85%)	**17 (85%)**
	c) Do evaluation activities measure outcomes, either for entire programme or components thereof?	26 (96%)	18 (90%)	**19 (95%)**
	d) Does the evaluation of the programme include relevant review/audit of the following activities:			
	Identification, risk assessment, admissions and referral activities?	24 (89%)	18 (90%)	**18 (90%)**
	Monitoring trends re demographics, risk factors, and types of abuse?	16 (59%)	15 (75%)	**15 (75%)**
	Documentation?	22 (82%)	17 (85%)	**18 (90%)**
	Referrals to CYF and the Police?	23 (85%)	18 (90%)	**19 (95%)**
	Case reviews?	24 (89%)	17 (85%)	**17 (85%)**
	Critical incidents?	21 (78%)	19 (95%)	**18 (90%)**
	Mortality morbidity review?	24 (89%)	19 (95%)	**18 (90%)**
	Policy and procedure reviews?	27 (100%)	20 (100%)	**19 (95%)**
	e) Do the evaluation activities include:			
	Multidisciplinary team members?	27 (100%)	20 (100%)	**20 (100%)**
	Police?	27 (100%)	19 (95%)	**18 (90%)**
	CYF?	27 (100%)	19 (95%)	**20 (100%)**
	Community agencies?	26 (96%)	19 (95%)	**17 (85%)**
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?	24 (89%)	16 (80%)	**18 (90%)**
8.3	Do health care providers receive standardized feedback on their performance and on patients from CYF?	23 (85%)	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?	11 (41%)	10 (50%)	**6 (30%)**
	b) community satisfaction?	23 (85%)	14 (70%)	**18 (90%)**

	"YES" responses	96 mo FU Hospitals (%)	108 mo FU DHBs (%)	120 mo FU DHBs (%)
8.5	Is a quality framework used to evaluate whether services are effective for Māori?	14 (52%)	9 (45%)	**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?	19 (70%)	14 (70%)	**18 (90%)**
8.7	Is the child abuse and neglect programme evident in the DHB quality and risk programme?	27 (100%)	19 (95%)	**17 (85%)**
8.8	Is the responsibility for acting on evaluation recommendations specified in the policies and procedures?	11 (41%)	11 (55%)	**14 (70%)**
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	0 (0%)	1 (5%)	**0 (0%)**
	b) 10-20 posters or images	1 (4%)	3 (15%)	**3 (15%)**
	c) >20 posters or images	26 (96%)	16 (80%)	**17 (85%)**
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	0 (0%)	1 (5%)	**1 (5%)**
	b) 10-20 locations	1 (4%)	4 (20%)	**4 (20%)**
	c) >20 locations	26 (96%)	15 (75%)	**15 (75%)**
9.3	Are there designated private spaces available for interviewing?			
	a) > 4 locations?	27 (100%)	20 (100%)	**20 (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?	24 (89%)	17 (85%)	**18 (90%)**
	b) Temporary safe shelter is available?	27 (100%)	18 (90%)	**19 (95%)**