HOSPITAL RESPONSIVENESS TO FAMILY VIOLENCE:

96 MONTH FOLLOW-UP EVALUATION

MINISTRY OF HEALTH
MANATŪ HAUORA

VIP
violence intervention programme

Interdisciplinary Trauma Research Centre
Te wairere au noa

AUT UNIVERSITY

HOSPITAL RESPONSIVENESS TO FAMILY VIOLENCE:
96 MONTH FOLLOW-UP EVALUATION

Jane Koziol-McLain, PhD, RN
Professor of Nursing

Claire Gear, BSocSci (Hons)
Research Officer

Acknowledgements

Text from ITRC Report No 10 is included with permission.

The evaluation team would like to thank the DHB Family Violence Intervention Coordinators, VIP portfolio managers and other steering group members that took part in site visits. We also give our appreciation to the Ministry of Health Portfolio Manager - Violence Prevention Issues Lead, Sue Zimmerman and to the National VIP Manager for DHBs, Miranda Ritchie.

This evaluation project was approved by the Multi-region Ethics Committee (AKY/03/09/218, including annual renewal August 2011).

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

2012
Interdisciplinary Trauma Research Centre
Auckland University of Technology
Private Bag 92006
Auckland, New Zealand 1142

ITRC Report No 11
ISSN 2230-6366 (Print)
ISSN 2230-6374 (Online)

CONTENTS

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 evaluation summary documents the result of measuring system indicators at 27 hospitals (20 DHBs), providing Government, MOH and DHBs with information on family violence intervention programme implementation. Based on previous audit scores and programme maturity, 10 DHBs transitioned to self audit only for the 96 month follow-up audit, all other data is based on external audit scores for 2011/2012.

- 100% of DHBs achieved the target score (≥ 70) for both partner abuse and child abuse and neglect intervention programmes at 30 June 2012, exceeding the 2012 MOH goal of 90%.

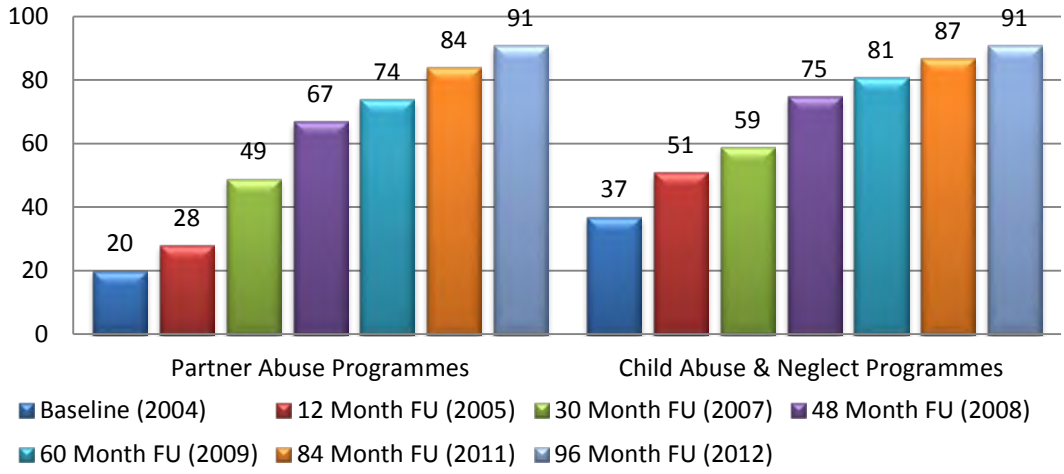


Figure 1. Median Hospital Violence Intervention Programme Scores (2004-2012)

- All DHBs have VIP systems in place to support an efficient, safe response to those experiencing partner abuse and child abuse and neglect.
- Roll out of staff training and delivery of VIP services is occurring across designated services (emergency, maternity, child health, sexual health, mental health and alcohol and drug).
- At the time of the audit 100% (n=20) of DHBs had a dedicated VIP coordinator position.
- 75% (n=15) of DHBs had been approved to deliver the Ministry-approved standardised national VIP training package.
- 60% of DHBs (n=12) had a VIP Quality Improvement (QI) Plan at the time of the audit.
- Internal audit processes monitoring policy implementation remain variable across DHBs, despite the VIP QI Toolkit resource.
- Internal chart reviews suggest that 30% of DHBS (n=6) are screening at least half of all eligible women.

VIP recognises culturally responsive health systems contribute to reducing health inequalities. Cultural responsiveness scores continue to increase over time. Overall DHB VIP cultural responsiveness scores increased 6% and 3% since the previous audit for partner abuse and child abuse and neglect programmes respectively. VIP Whānau Ora advisors continue to support programmes in applying the principles of Whānau Ora and to achieve cultural indicators that performed poorly in past audit periods (see page 20).

New Zealand District Health Boards (DHBs) continue to make significant progress in developing systems for responding to women and children at risk for ongoing exposure to family violence. All DHBs achieved the benchmark target score in both their partner abuse and child abuse and neglect programmes. While programmes are doing well overall, there are still significant gaps. Implementation of the Ministry's Family Violence Intervention Guidelines: Child and Partner Abuse [3] (*The Guidelines*) is still in progress. DHBs are continuing to roll out VIP in designated services and increasing service delivery by trained staff. Quality monitoring and improvement activities continue to present challenges to programme development. Improved leadership, coordination, quality monitoring and evaluation activities are required to enhance programme integration and inter-sectoral collaboration.

BACKGROUND

Family violence (FV) is recognised to have significant social, economic, and health tolls internationally and in Aotearoa New Zealand.[3-11] With the identification of family violence as a preventable public health problem,[12] the Ministry of Health ('the Ministry') began a Family Violence Health Intervention Project in 2001 (see Appendix A). In 2007, the Ministry launched the renamed Violence Intervention Programme (VIP) in District Health Boards (DHBs). 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 is part of 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.[13]

VIP is premised on a standardised, comprehensive systems approach supported by six programme components funded by the Ministry (Figure 2). These components include:

- District Health Board Family Violence Intervention Coordinators (FVIC).
- Ministry of Health Family Violence Intervention Guidelines: Child and Partner Abuse.
- 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 VIP Quality Improvement Toolkit.
- Technical Advice and support provided by a National VIP Manager for DHBs, Whānau Ora Advisor, and biannual national and regional FVIC networking meetings.
- National training contracts (GPs, midwives, primary care providers and DHB staff).
- External evaluation of DHB family violence responsiveness.

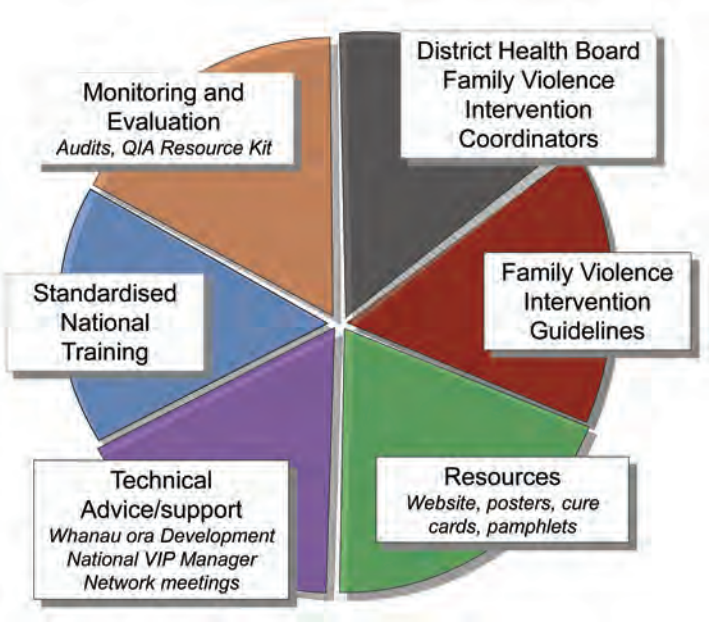


Figure 2. Ministry of Health VIP Systems Support Model (Secondary Care)

The VIP external evaluation project, operating since 2003, provides information to DHBs and the Ministry about the implementation of family violence programmes.[a] This 96 month follow-up report documents the development of DHB family violence systems across seven rounds of hospital audits. This longitudinal data contribute to the nationwide picture of family violence healthcare initiatives across Aotearoa New Zealand acute care services. The quantitative data are the result of applying standardised audit tools to measure system indicators at 27 hospitals across 20 District Health Boards.

The 96 month follow-up evaluation mirrored the 84 month follow-up[14] evaluation processes with the following change:

[a] For the full series of evaluation reports go to: www.aut.ac.nz/vipevaulation

- DHBs that had achieved the Ministry VIP target score (>70) for both partner abuse and child abuse and neglect programmes in the 84 month follow-up audit and had established programme implementation across several services over time, transitioned to self audit only.

The transition to self audit processes recognises increasing programme maturity across DHBs and supports identification of strengths, weaknesses, opportunities for improvement and prevention of problems.[15,16]

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. Do self audit scores accurately represent programme system development?

The evaluation is an important component of the Ministry's efforts to reduce and prevent the health impacts of family violence. Evaluation data supports an evidence-based programme, providing information to guide DHB and Ministry decisions and resource investment (Letter to DHBs, Ministry of Health, August 2010).

METHODS

Participation in the audit process was specified in Ministry VIP contracts with DHBs. Ninety-six month follow up audits were conducted in the 20 DHBs covering 27 acute secondary and tertiary public hospitals across New Zealand (see Appendix B).

All DHBs were invited to submit self audit data 12 months following their previous audit. A session explaining self audit purpose, procedures and best practice processes (such as 'plan ahead') was presented at national FVIC network meetings in 2010 and 2011.

FVIC were requested to complete and forward self audit documentation including:

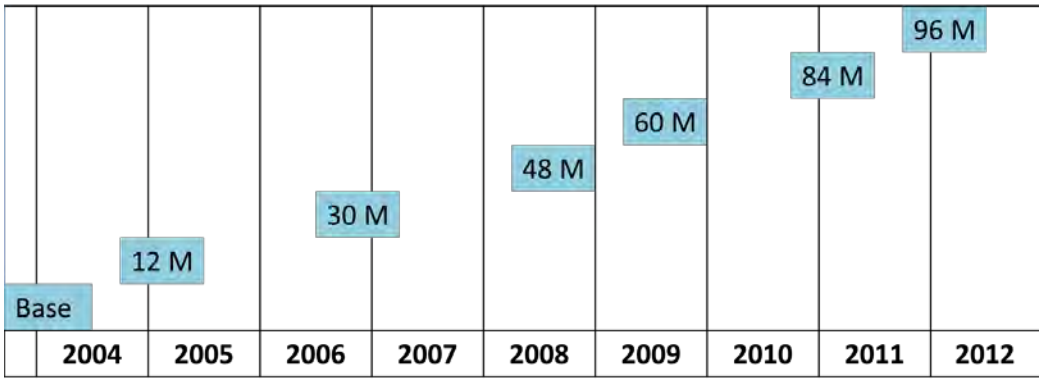
1. Partner Abuse Audit Tool
2. Child Abuse and Neglect Audit Tool
3. Programme Information Form (Appendix C)
4. Self Audit Report (for self audit only DHBs).

In addition to self-audit, external audit site visits were conducted at 10 DHBs (Table 1). These included 3 DHBs which did not achieve the MOH target score (70 in both PA and CAN programmes) at the last audit and 7 DHBs (out of 9) that had been invited to participate in an external audit due to identified programme vulnerabilities.

96 month follow-up self and external audit data were collected between October 2011 and May 2012. The seven audit round periods are shown in Figure 3. The evaluation project was approved by the Multi-region Ethics Committee (AKY/03/09/218 with annual renewal including 10/08/2011).

Table 1. Self and External Audit Assignments for 96 month follow up

Self Audit Only (14 hospitals; 10 DHBs)	External & Self audit (13 hospitals; 10 DHBs)
Auckland	Canterbury
Bay of Plenty	Capital & Coast
Hawke's Bay	Counties Manukau
MidCentral	Hutt Valley
Nelson Marlborough	Lakes
South Canterbury	Northland
Southern	Tairawhiti
Wairarapa	Taranaki
Waitemata	Waikato
West Coast	Whanganui



Note: M=months from baseline.

Figure 3. Audit Round Time Periods

Audit Tool

Quantitative external 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*[17,18] for the bicultural Aotearoa New Zealand context. The audit tools assess programmes against criteria for an ideal programme given current knowledge and expertise.

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.[2] This *Revised CAN Tool* was subsequently used for the 48, 60, 84 and 96 month follow-up audits.

The audit tools have been available (open access at www.aut.ac.nz/vipevaluation) as interactive Excel files since 2008. 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.[19-21] 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 2. 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 external 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.

Procedure

Evaluation procedures were conducted based on a philosophy of supporting programme leaders in building a culture of improvement. Integrating the evaluation into the VIP systems approach allowed for clear and consistent communication and resources to support audit activities. Details of evaluation processes are outlined in Figure 4 and Appendix E. The 96 month follow up process (Round Two in Figure 4) began with a letter from the Ministry advising DHB Chief Executives of the upcoming 2011-2012 audit rounds.

Shortly after DHB notification by the Ministry, external audit staff contacted VIP managers and FVIC by e-mail to outline whether they were scheduled for self audit only (n=8), self and external audit (n=3), or whether they could elect self audit only or combined self and external audit (n=9). A confirmatory e-mail identified site visit dates for DHBs scheduled or requesting an external audit.

Where an external audit was conducted, FVIC were requested to submit an audit day itinerary outlining audit participants, venue and an agenda to include a debriefing meeting at the end of the site visit day. Debriefing meetings were to be attended by DHB VIP leaders such as senior management, FVIC, audit participants, and steering group members. Debriefing meetings provided the opportunity to discuss programme highlights and challenges alongside preliminary audit results.

Reporting

Where external audits were conducted, a draft report was provided to the DHB FVIC or designee by the evaluation team. The report included a summary outlining DHB programme progress, strengths and recommendations for improvement, external audit scores and an indicator table of achievements and suggested improvements. Self audit scores were also noted within the report. FVIC were asked to involve relevant others (e.g., DHB VIP portfolio managers, 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, FVIC and the Ministry.

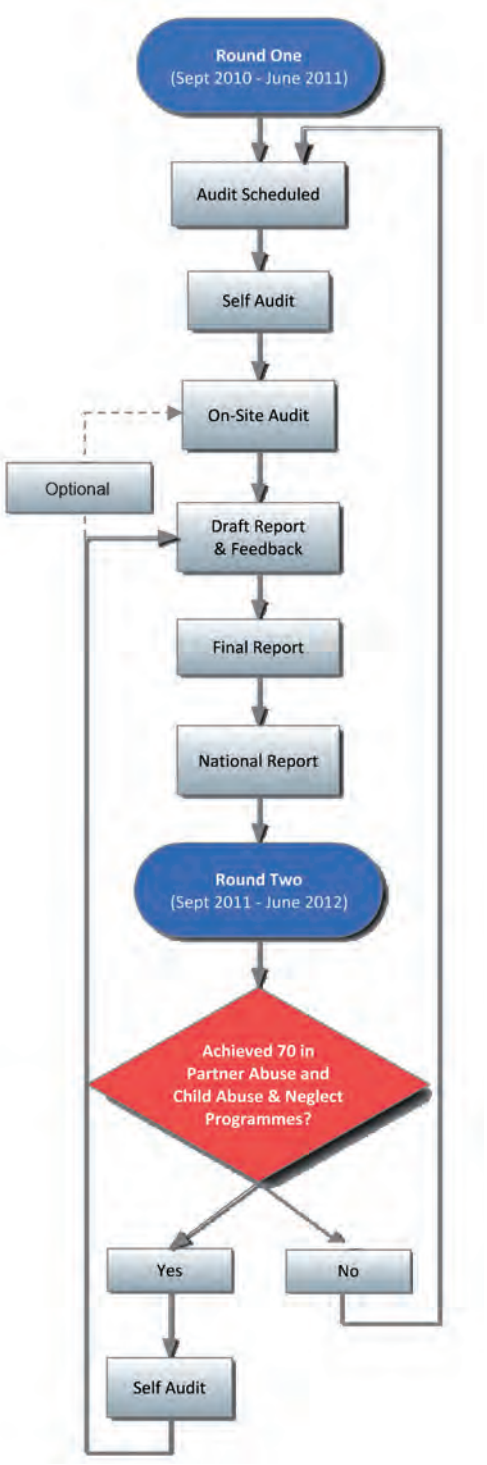


Figure 4. 2010 – 2012 Audit Plan

Documentation received from self audit only DHBs (n=10) were reviewed by the external evaluation team. Modifications to the submitted self audit report were made to correct errors and enhance readability. Brief external 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, FVIC and the Ministry.

Analysis Plan

Self and external audit data were exported from Excel audit tools into an SPSS Statistics (Version 17) file. Score calculations were confirmed between Excel and SPSS files. Programme information (Appendix C) data were also entered into an SPSS file. All analyses were conducted in SPSS.

Analysis began with assessment of agreement between self audit and external audit values for all indicators, domain and overall scores among the 10 DHBs that had both self and external audit data. The decision was then made to amalgamate the external and self audit scores. This means that 96 month follow up scores represent external audit scores for the 13 hospitals (10 DHBs) that had an external evaluation and self audit scores for the remaining 14 hospitals (10 DHBs). By 2014, it is expected that only self audit scores will be reported.

- *96 month follow up results combine external audit scores for 13 hospitals (10 DHBs) and self audit scores for the remaining 14 hospitals (10 DHBs).*

In this report we present baseline, 12, 30, 48, 60, 84 and 96 month follow-up domain and overall Delphi scores for comparison. 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 of hospitals has been maintained across evaluation reports with the exception of league tables and some indicator reporting, which are reported by DHB. Recognising the potential of individual extreme scores to influence mean scores, we favour reporting medians (and box plots).

FINDINGS

Partner Abuse Programmes

- *At the 96 month follow-up, the partner abuse intervention programme score ranged from 74 to 98, with 91 as the typical (median) score.*
- *100% of DHBs achieved an overall partner abuse programme score ≥ 70, exceeding the 2012 MOH goal of 90%.*

As demonstrated in Figure 5, partner abuse programme scores have increased substantially over time. Most recently, the median score increased from 84 at the 84 month follow up audit to 91 at the 96 month follow up. The proportion of hospitals achieving the minimal achievement target score of 70 increased from 93% to 100% between the 84 and 96 month follow up audits (see also the section on League tables, page 13). Appendix G provides the data supporting the Figures and Tables in this section.

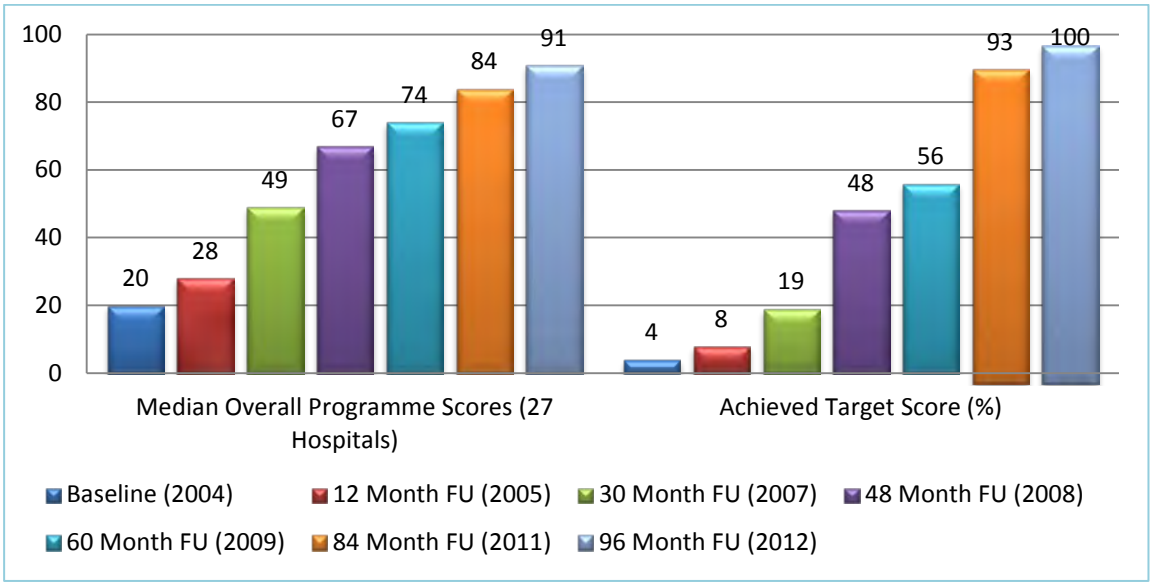


Figure 5. Partner Abuse Programme Scores 2004-2012

Variability in scores over time is shown in Figure 6. 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 at 12, 30, 48 and 60 month audits = 21.9, 26.2, 21.6 and 20.1 respectively), indicating a period of change. At the 84 and 96 month follow up, audit scores were again consistent (SD=11.5, 6.3), but now at the higher range of the scale.

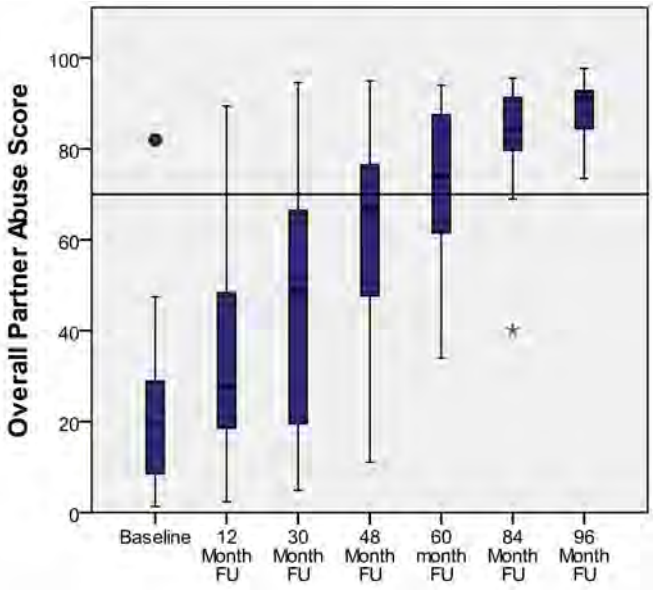


Figure 6. Overall Partner Abuse Score Distributions over Time

Partner Abuse Programme Indicators

Many indicators of a systems approach for responding to partner abuse are now in place across all 27 hospitals in all DHBs. Selected high achieving partner abuse programme indicators are highlighted below. Frequencies for individual partner abuse programme tool indicators are provided in Appendix H.

All 27 (100%) hospitals employ an identifiable partner abuse intervention programme coordinator.

All 27 (100%) hospitals have endorsed policies regarding the assessment and treatment of victims of partner abuse.

All 27 (100%) hospitals have a formal partner abuse response training plan; 26 (96%) hospitals (19 DHBs) have agreements with regional refuge services or similar to support health professional training.

All 27 (100%) hospitals have instituted partner abuse screening in one or more services.

All 27 (100%) hospitals have conducted quality improvement activities since the last audit.

Some indicators, though improving over time, are not yet present across all hospitals (see below).

18 (67%) hospitals have written procedures outlining security's role in working with partner abuse victims and perpetrators.

12 (44%) hospitals have an Employee Assistance Programme (or similar) that maintains specific policies and procedures for responding to employees experiencing partner abuse.

As the majority of programmes have the infrastructure in place to support a systems approach for responding to partner abuse, there is increasing attention on evaluating service delivery. The diffusion of partner abuse screening across services and rate of screening of eligible women within those services are useful measures of programme implementation.

The Ministry funds DHBs to implement VIP in the following six targeted services:

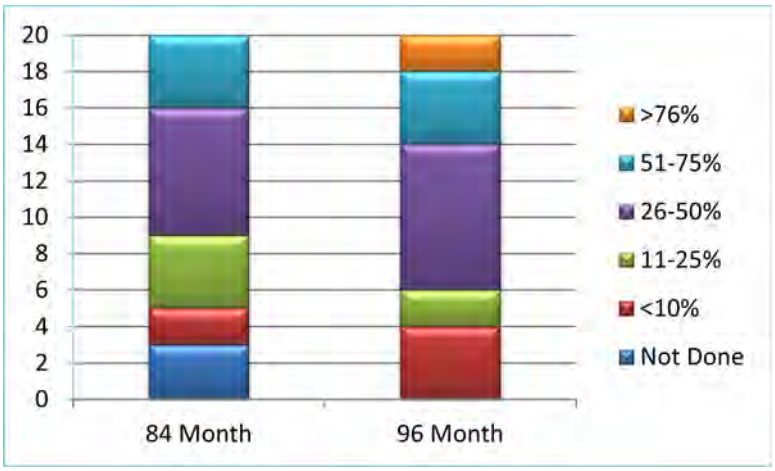
- Child Health
  - acute care
  - community
- Maternity
- Sexual Health
- Mental Health
- Alcohol and Drug
- Emergency Department

While all DHBs had implemented routine screening in at least one service at the time of the 96 month follow up audit, many were still in the process of programme diffusion across targeted services. A few DHBs were in the process of providing support for screening beyond the identified Ministry targeted services (such as in medical wards and primary care services).

To assist standardisation of data collection, the *Quality Improvement Toolkit* included an Excel file for partner violence screening data entry and analysis. VIP staff were beginning to gain experience in standardising routine data collection (such as frequency of auditing and number of random charts selected), though for the most part, collection remained variable. The reader is cautioned that the summary data are likely to include significant error and future reporting

is recommended with more attention to data collection rigour, with differentiation of screening rates by targeted service.

All DHBs now monitor their intimate partner violence screening rate across one or more services. The proportion of eligible women screened is improving over time (Figure 7). It is encouraging that almost one in three DHBs report screening at least half of eligible women in selected services. Equally, however, it demonstrates that increased attention is needed to promote the diffusion of partner abuse screening in practice. The goal would be for all DHBs to screen near 100% of eligible women.



Six DHBs report screening at least half of eligible women at the 96 month follow-up, compared to 4 DHBs at 84 month follow-up.

Figure 7. Summary Screening Rate of Eligible Women (n=DHBs)

One measure of screening quality is the rate of partner abuse identified as a result of screening, the 'disclosure rate'. Research and practice identify that the quality of screening (including the environment, and screener knowledge and attitude) will influence whether or not a woman will choose to disclose abuse.[23-25] With New Zealand population past year partner abuse rates among women estimated at 5%,[8,26] 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.[8,27,28] Disclosure rates (and past year incidence) would be expected to vary across services, with higher rates for example in mental health, alcohol and drug and sexual health services. To date, disclosure rates have not been routinely measured and analysed. Anecdotally, reported disclosure rates are often less than 1%, indicating the need to consider strategies to improve performance.

Other potential measures of service delivery are the rates of completed risk assessment and provision of specialised family violence services (at the time or through referral) to women who disclose abuse. This data is not currently available. Most DHBs (15, 75%) measure community satisfaction with the partner abuse programme, such as from Refuge services and Police. Few, however, include gathering client satisfaction data.

Partner Abuse Programme Domains[a]

All nine partner abuse programme domain scores increased or remained the same between the 84 and 96 month follow up audits (Figure 8). The most important median score increase was in the *Evaluation Activities* domain, increasing from 66 to 80. All median domain scores now exceed 70. Four hospitals have yet to achieve a score of 70 for *Evaluation Activities* and five have yet to achieve a score of 70 for *Screening and Safety Assessment* (see Appendix G).

[a] Tool domains are described in Table 2 (page 6).

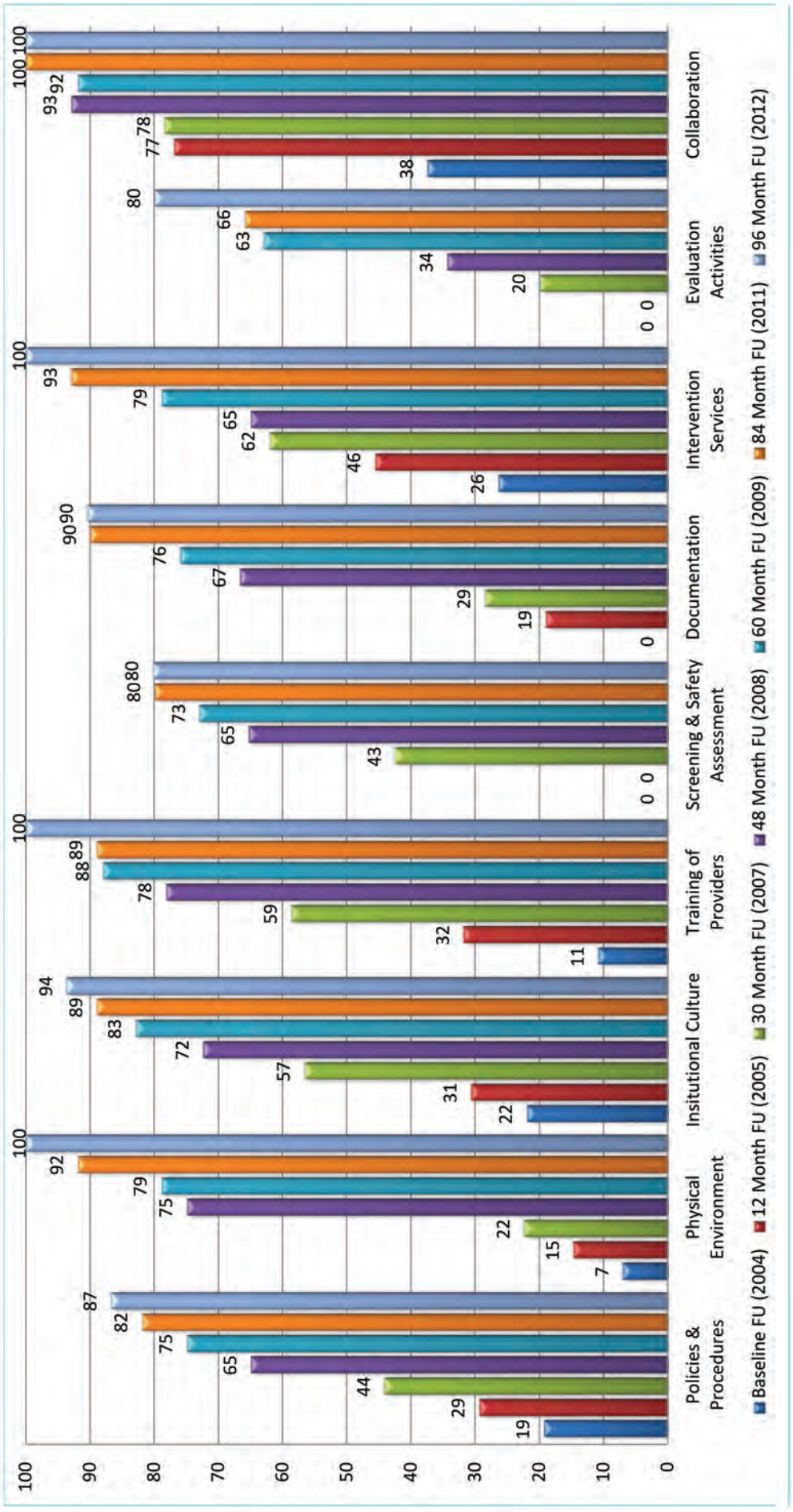


Figure 8. Partner Abuse Programme Domain Median Scores

Partner Abuse Programme League Tables

Hospital league tables provide a pictorial representation of development across the seven audit rounds from 2004 to 2012 (Figure 9, next page). The horizontal line indicates the target minimum achievement score of 70. The development of programmes over time apparent in Figure 8 is impressive.

A **DHB** league table for the 96 month follow up audit is presented in Table 3. The amount of change since the last audit (absolute score difference) ranged from a decrease of 2 to an increase of 33 (achieved by Hutt Valley DHB). Note the DHB median score (89) varies slightly from the hospital median score (91).

Table 3. 96 Month Follow-Up Partner Abuse DHB League Table

Rank		Score	Target (70)	Change from 84M
1	Hawke's Bay (S)	98		4
2	Bay of Plenty (S)	97		6
3	Waitemata (S)	96		1
4	MidCentral (S)	95		3
5	Northland	93		11
6	Counties Manukau	92		2
7	Canterbury	92		12
8	South Canterbury (S)	92		6
9	Southern* (S)	91		4
10	Wairarapa (S)	90		1
11	Auckland (S)	89		-2
12	Whanganui	89		5
13	Lakes	86		16
14	Waikato	85		14
15	West Coast (S)	84		-2
16	Taranaki	83		1
17	Tairawhiti	82		3
18	Nelson Marlborough (S)	81		-1
19	Capital & Coast	79		11
20	Hutt Valley	74		33
	DHB Median	**89**		4

Notes: (S) Self Audit; * Southern score change based on lowest 84 Month FU DHB score

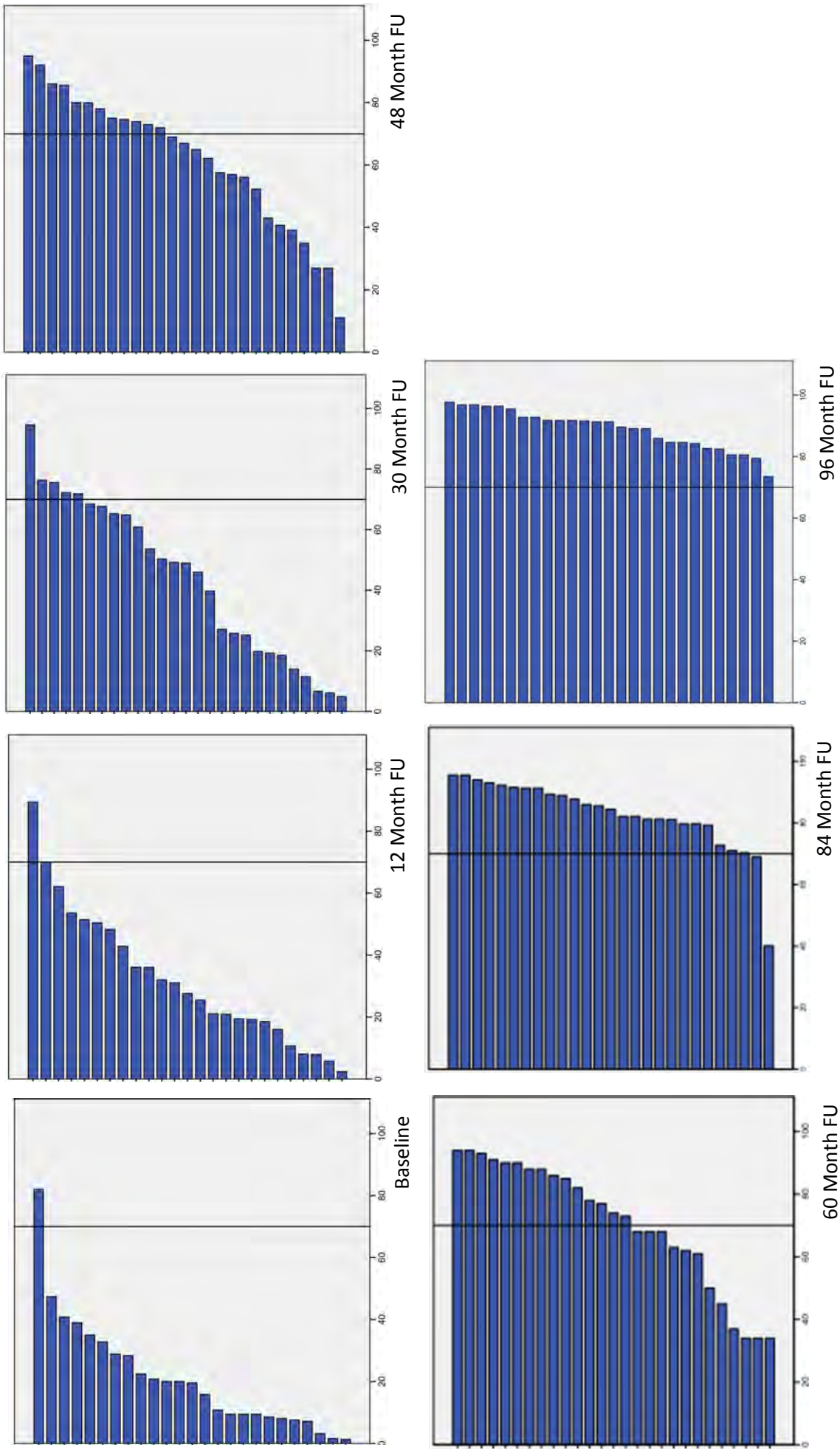


Figure 9. Partner Abuse Intervention Hospital League Tables
Note: Similarly ranked bars do not represent the same hospital across the six graphs.

Child Abuse and Neglect Programmes

- *At the 96 month follow-up, the child abuse and neglect intervention programme score ranged from 79 to 100, with 91 as the typical (median) score.*
- *100% of DHBs achieved an overall child abuse and neglect programme score ≥ 70, exceeding the 2012 MOH goal of 90%.*

As demonstrated in Figure 10, child abuse and neglect programme scores have increased substantially over time. Most recently, the median score increased from 87 at the 84 month follow up audit to 91 at the 96 month follow up. Appendix I provides the data supporting the Figures and Tables in this section.

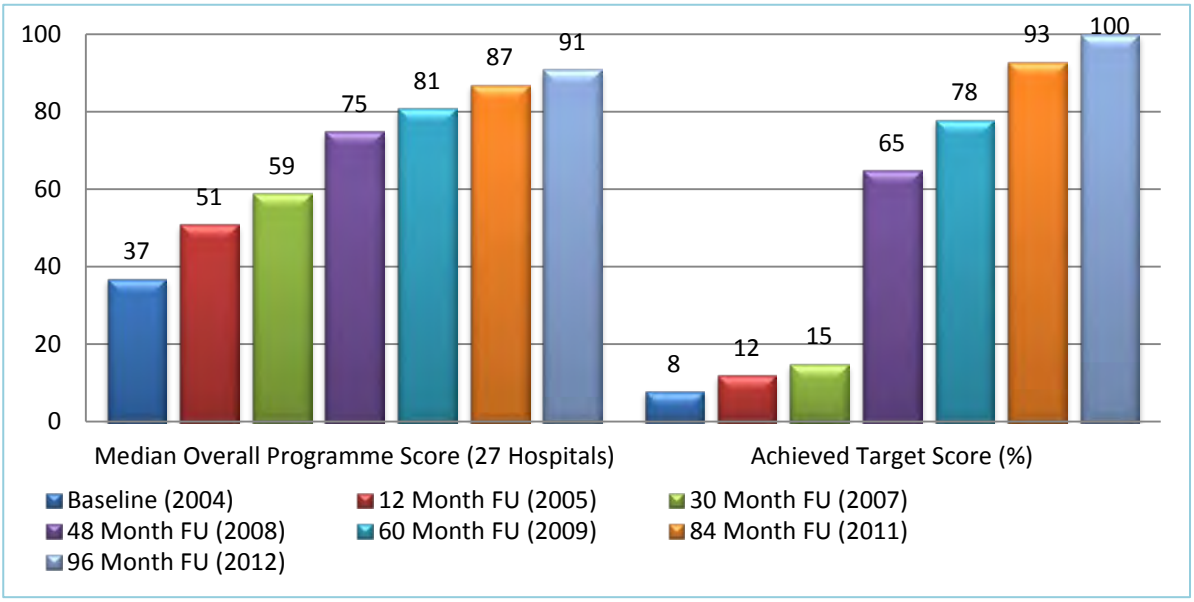


Figure 10: Child Abuse and Neglect Programme Scores (2004-2012)

At baseline, child abuse and neglect programme scores were higher compared to partner abuse programme scores (median =37 vs 20 respectively). There has also been less variability in scores over time (See Figure 11). The maximum score variation for child abuse and neglect programmes (SD=19.4) was at baseline, compared to at the 30 month follow-up audit for partner abuse programmes. Scores at the 84 and 96 month follow-up audits were consistently high (SD=8.6 and 5.0 respectively), with a few lower scoring outliers.

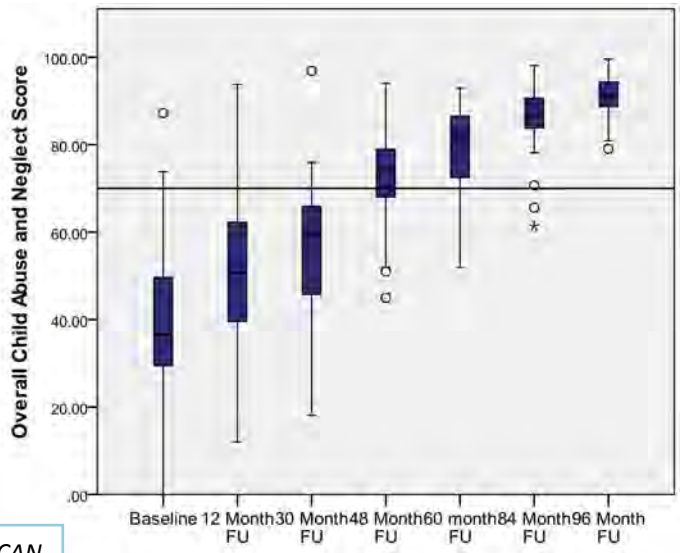


Figure 11: DHB Overall Child Abuse and Neglect Score Distributions over Time

Note: To increase content validity, the *Revised CAN Audit Tool* was developed in 2007 and implemented at the 48 month follow up audit.[1,2] The revised tool included an additional 28 indicators and a new *Safety and Security* domain. The 48 month follow up report[1] includes a comparison of the original and revised tool.

CHILD ABUSE AND NEGLECT PROGRAMME INDICATORS

Most indicators of a systems approach for responding to child abuse and neglect are in place across all 27 hospitals in 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 J.

All 27 (100%) hospitals have a clinical assessment policy for identifying signs and symptoms of child abuse and neglect and for identifying children at risk.

All 27 (100%) hospitals' child abuse and neglect programmes collaborate with Child, Youth and Family and the Police in programme planning and safety planning for children at risk.

21 (78%) hospitals have protocols for collaborative safety planning that explicitly involve primary health providers; 19 (70%) involve primary health care services in discharge planning.

24 (89%) hospitals have a local alert system in the acute care setting recording any concerns about children at risk of abuse and neglect; 2 DHBs had implemented the National Child Protection Alert System.

All 27 (100%) hospitals include their child abuse and neglect programme in their DHB Quality and Risk programme.

19 (70%) hospitals record, collate and report to the DHB data related to child abuse and neglect assessment referrals and alert placements; 16 (59%) hospitals monitor demographics, risk factors and types of abuse trends.

DHBs have achieved significant infrastructure to support a systems approach for responding to child abuse and neglect that includes collaboration with Child, Youth and Family and the Police. Multi-Disciplinary Team (MDT) processes are improving over time as working relationships within and external to DHBs are developed. It is anticipated that working relationships promoting health and safety for children will further improve as regions adopt the revised national Memorandum of Understanding between DHBs, CYF and Police, and work with CYF-appointed DHB liaison social worker leaders.

Internal systems for recording abuse and neglect concerns are common among hospitals (89%). At the time of the 96 month follow-up audit, two DHBs had implemented the National Child Protection Alert System (NCPAS), a component of the VIP programmes developed between the Ministry, the NZ Paediatric Society of New Zealand Child Protection Special Interest Group and DHBs. An additional five DHBs were working to join NCPAS.

All DHBs have protocols for safety planning for children identified at risk. Collaborating with primary health care providers occurs in three quarters of hospitals (21; 78%), this is an increase from 11 hospitals at the 84 month follow-up. Nineteen (70%) hospitals coordinate referral processes for care transitions of children at risk between secondary and primary care.

Child injury flow charts raise awareness of child abuse and neglect and increase the number of cases identified as requiring consultation for suspected abuse. [29,30] Twenty-six hospitals (96%)

had a standardised child injury assessment documentation form. The age group to which the child injury flow chart was applied, however, ranged across hospitals from children under 2 years of age to under 18 years of age. Ten hospitals reported reviewing emergency department child records for completed injury flow charts. Sixteen hospitals (59%) reported reviewing Reports of Concern submitted to Child, Youth and Family from the DHB; between 6 and 531 reports were reviewed during a single audit period.

Child Abuse & Neglect Programme Domains[a]

All nine child abuse and neglect programme median domain scores exceeded 70 (Figure 12). Similar to partner abuse programmes, *Evaluation Activities* was the least developed, 9 hospitals had yet to achieve a score of 70 for *Evaluation Activities*. Three hospitals had yet to achieve a score of 70 for *Documentation.* All hospitals achieved the target score for the remaining seven domains (see Appendix G).

[a] Tool domains are described in Table 1 (page 5).

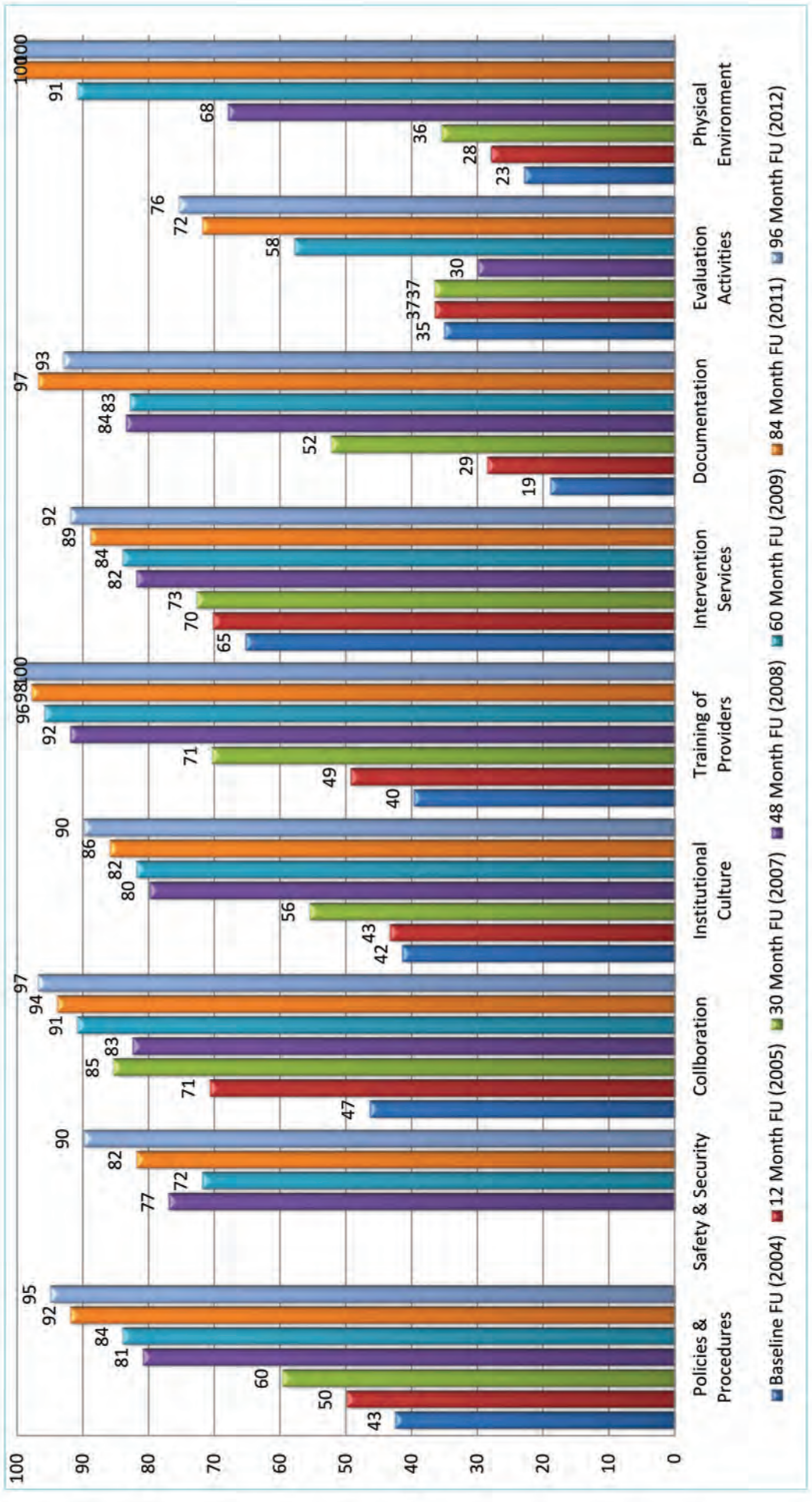


Figure 12: Child Abuse and Neglect Programme Domain Median Scores
Note: The Revised Child Abuse & Neglect audit tool, with the new *Safety & Security* domain, was implemented beginning with the 48 month follow up audit.

Child Abuse and Neglect Programme League Tables

Hospital league tables provide a pictorial representation of development across the seven audit rounds from 2004 to 2012 (Figure 13). The horizontal line indicates the target minimum achievement score of 70. The development of programmes over time is impressive.

A **DHB** league table for the 96 month follow up audit is presented in Table 4. The amount of change since the last audit (absolute score difference) ranged from no change to an increase of 20. Note the DHB median score (90) varies slightly from the hospital median score (91).

Table 4. 96 Month Follow-Up Child Abuse and Neglect DHB League Table

Rank		Score	Target (70)	Change from 84M
1	Auckland (S)	100		4
2	Waitemata (S)	100		1
3	Hawke's Bay (S)	96		6
4	Canterbury	94		3
5	Bay of Plenty (S)	94		9
6	Wairarapa (S)	94		4
7	MidCentral (S)	92		5
8	Southern* (S)	92		1
9	Counties Manukau	91		7
10	South Canterbury (S)	91		11
11	Nelson Marlborough (S)	90		4
12	Capital & Coast	89		2
13	Northland	89		3
14	Waikato	89		7
15	West Coast (S)	88		2
16	Whanganui	87		0
17	Taranaki	86		3
18	Lakes	85		20
19	Tairawhiti	81		10
20	Hutt Valley	79		18
	DHB Median	**90**		4

Notes: (S) Self Audit; * Southern score change based on lowest 84 Month FU DHB score

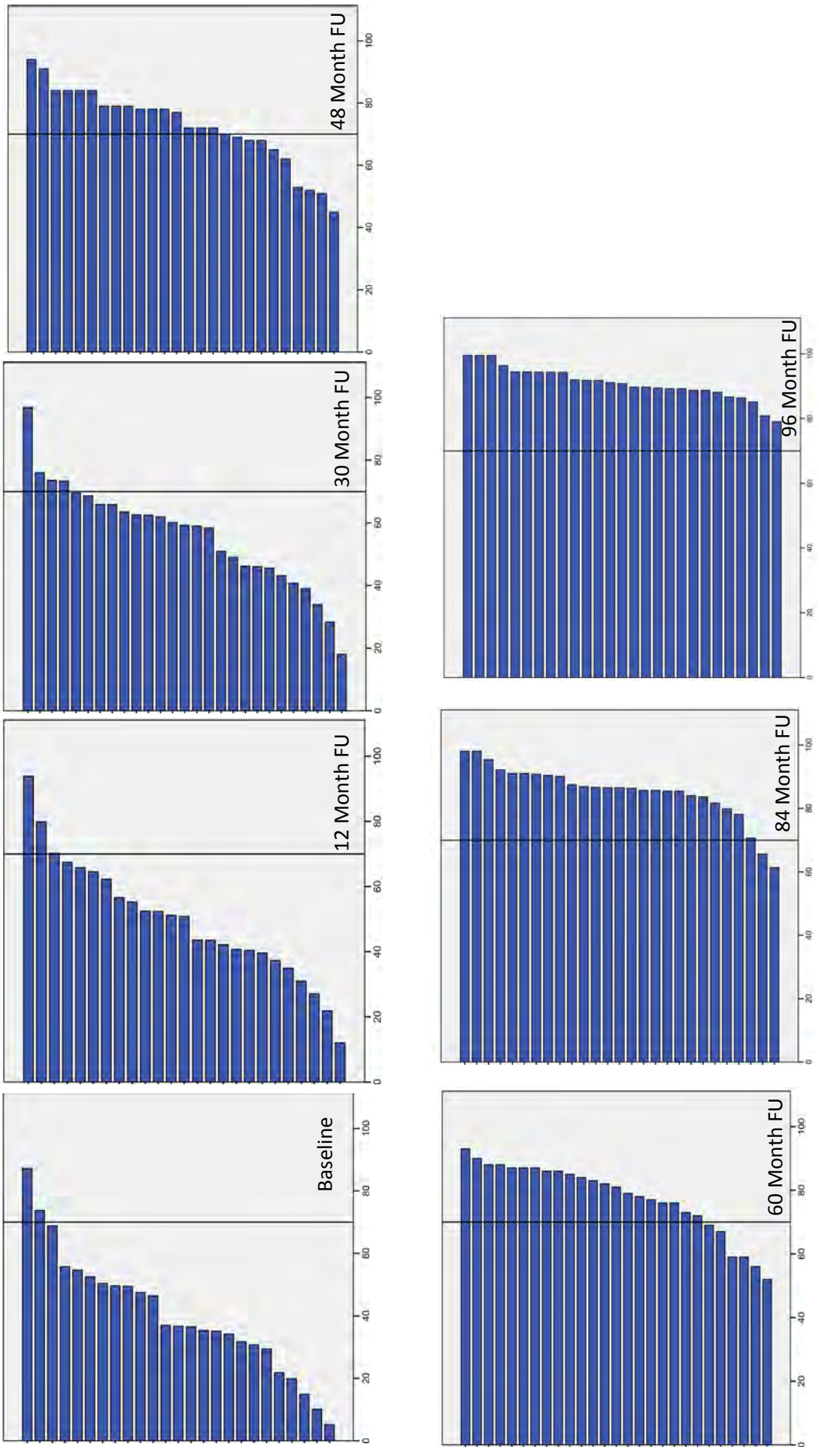


Figure 13. Child Abuse and Neglect Hospital League Tables

Notes: Similarly ranked bars do not represent the same hospital across the six graphs. The Revised CAN audit tool was implemented beginning with the 48 month follow up audit.

Cultural Responsiveness and Whānau Ora

- *Hospital 96 Month follow-up Partner Abuse programme cultural responsiveness scores ranged from 77 to 100, with a median score of 90.*
- *Hospital 96 Month follow-up Child Abuse and Neglect programme cultural responsiveness ranged from 68 to 100, with a median score of 89.*

VIP recognises culturally responsive health systems contribute to reducing health inequalities. The following Figure (Figure 14) summarises the sub-set of audit tool indicators evaluating cultural responsiveness within VIP programmes across the seven evaluation periods. Cultural responsiveness scores continue to increase over time.

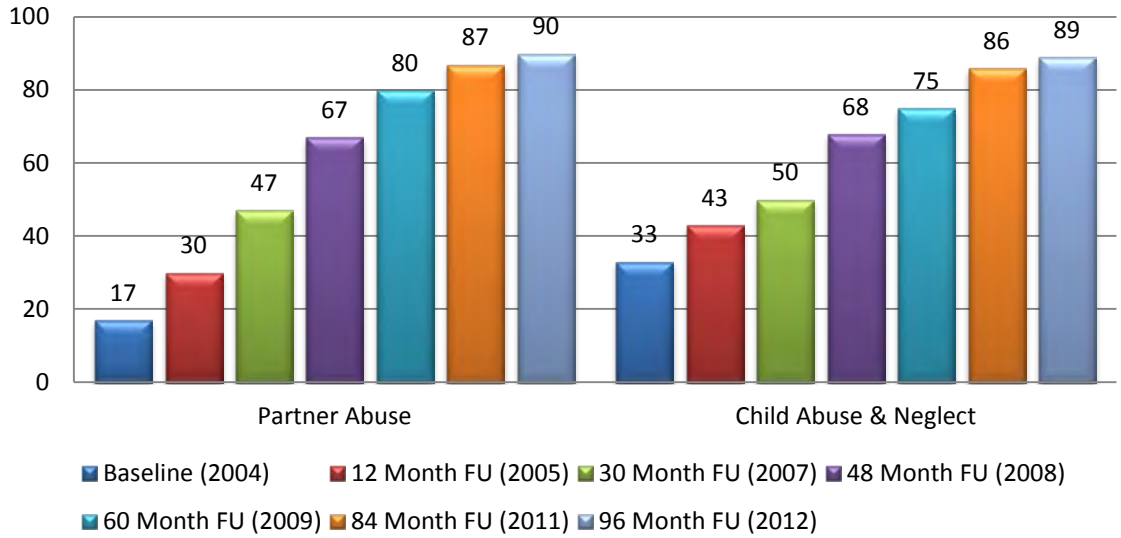


Figure 14. Median Hospital VIP Cultural Responsiveness Scores 2004-2012 (N=27 hospitals)·

In addition to overall cultural responsiveness scores, VIP has focussed on addressing four selected indicators (Figure 15). The selected indicators are increasingly evident in VIP, though further development is needed. For example, six and nine DHBs report evaluating whether partner abuse and child abuse and neglect VIP services, respectively, are effective for Māori.

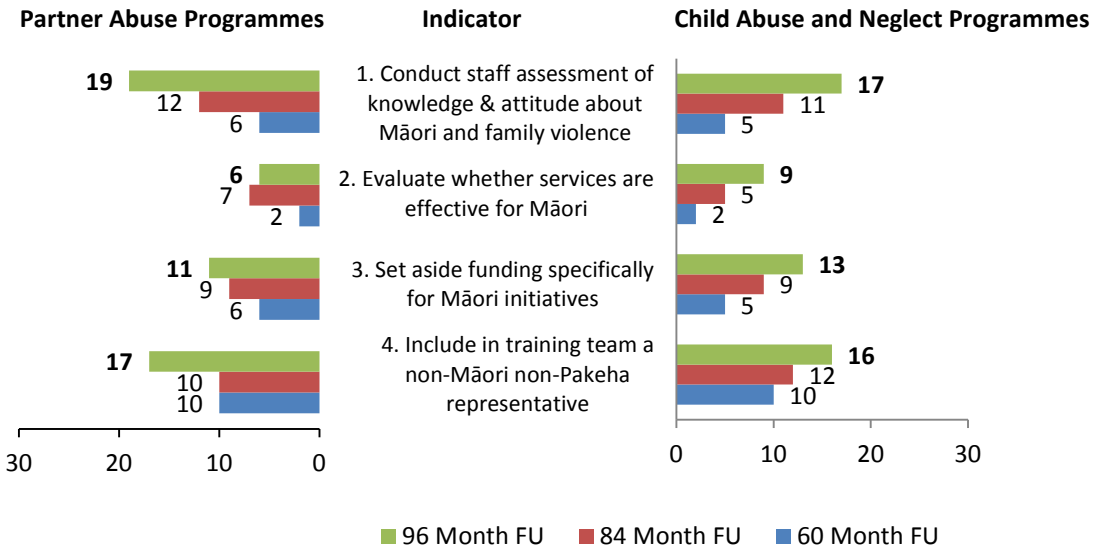


Figure 15. Selected Cultural Responsiveness Indicators (N=20 DHBS)

TRANSITION TO SELF AUDIT

In this section we address the transition to self audit. We provide data comparing self audit scores to external audit scores. This was the second audit round in which DHB VIPs submitted self audit data.

All DHBs submitted self audit scores for partner abuse and child abuse and neglect audit tools. In importing and checking calculations in SPSS some errors in submitted self audit Excel files were noted and subsequently corrected. A full quality check of submitted self audits, however, was not conducted. Errors and explanations for identified errors are listed below:

- Incorrect score entered in the proper cell - user would have manually entered the incorrect score, either over-riding or not using the macro.
- Score entered in the wrong cell - user would have manually entered a score in the wrong cell, over-riding or not using the macro.
- Category score incorrect – (a) user would have manually entered an incorrect category score, or (b) the macro calculation was incorrect due to source cell errors (see previous 2 bullets).
- Presence of poster/brochures not entered or not in agreement with the count field (PA tool only) – missing value, or incorrect data entry. For non-Pakeha posters and brochures this error may result in an incorrect cultural responsiveness score.
- Several cultural indicators in the CAN tool, if user selects YES (1) and then NO (0), the score does not return to zero – this is a file versus user error.

Additional training for FVIC would serve to improve self audit reliability, particularly in managing Excel file macros and cell entry, and logic checks between domain items and domain scores.

In 10 DHBS, external audits were conducted in addition to the self audit. The external auditor reviewed the partner abuse programme at all 10 DHBs. The child abuse and neglect programme was reviewed at only 8 DHBs, as the other 2 DHBs evidenced established, mature child abuse and neglect programmes over time.

The overall partner abuse self and external audit score difference (self audit minus external audit score) was less than 1 (0-.55; 85.9 vs 86.4). The overall child abuse and neglect mean score difference was also less than 1 (0.79; 87.3 vs. 86.7). There were, however important domain differences (see Table 5 and Figures 16 and 17). Evaluation activities were often overstated and physical environment understated.

Table 5. Significant differences between domain self and external audit scores (n=10).

Programme	Domain	Mean Difference	95% Confidence Interval of the Difference	
			Lower	Upper
CAN	Safety & Security	11.7	4.42	18.98
	Documentation	11.1	1.99	20.20
	Evaluation Activities	16.9	7.658	26.042
	Physical Environment	-14.4	-26.74	-2.059
PA	Policies & Procedures	9.00	2.1	15.9
	Collaboration	-5.4	-10.8	-0.10

Note: Difference= self audit minus external audit score; CAN=child abuse and neglect programme; PA=partner abuse programme

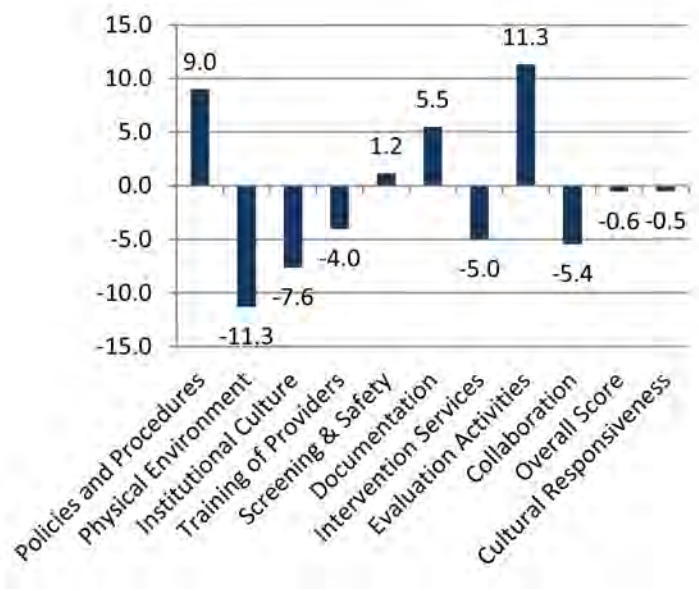


Figure 16. Partner abuse external and self audit domain differences.

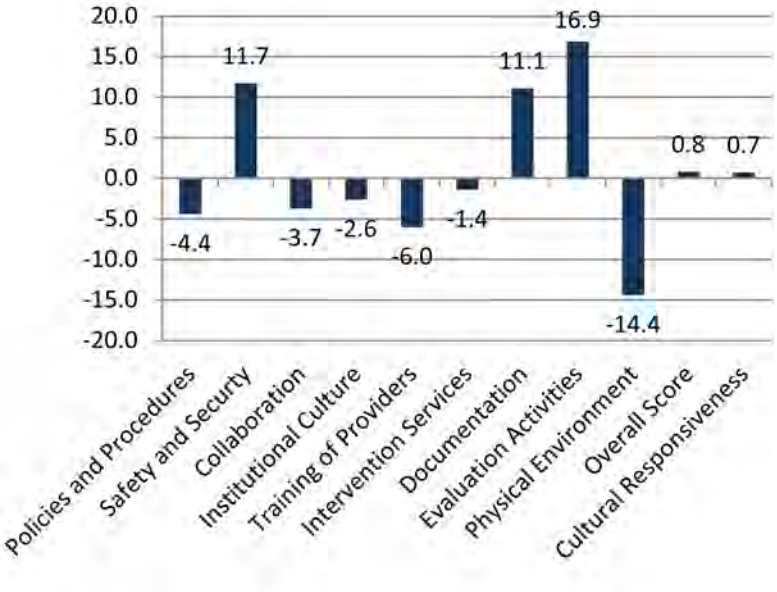


Figure 17. Child abuse and neglect external and self audit domain score differences.

Along with submitting Delphi audit tools, DHBs submitted a completed Programme Information Form (Appendix C). In the Programme Information Form, internal audit data were requested. Review of internal audit data indicated that there is significant variation from the VIP QI Toolkit guidelines for internal audit. Several issues are noted below:

- The time period for selecting records to review was variable from 2 days to 12 months.
- The number of eligible records reviewed was often less than the number recommended in the Toolkit.
- Data provided was typically the most recent audit, while in other instances data had been merged across two or more audits.
- There is no allowance for reporting variation in screening rates across hospitals within a DHB.
- The patient population (census) of various services is unknown.
- The proportion of personnel in a service who have completed VIP training is unknown.
- The definition of 'eligible' and 'screened' is variable. For example, in some locations screening documentation achievement includes when 'not screened' is documented.
- Disclosure data were rarely provided.
- The applicable age for completion of child injury flow charts ranges from under 2 to under 18 years of age.

These issues highlight the need for supporting more rigorous and consistent internal audit processes to inform improving service delivery quality.

PROGRAMME IMPLICATIONS

VIP programme funding is continuing and will support DHBs in transitioning to self audit of programme system indicators by July 2014. In addition to submitting audit tools, DHBs will analyse audit results to inform local quality improvement action plans.

There is a need to increase implementation and value of quality improvement activities.

Variation in internal quality monitoring was noted across DHBs. A need for clearer standards, resources and quality monitoring skills and knowledge was identified. Future monitoring will focus on activities such as monitoring partner abuse screening, assessment and disclosure rates, with national 'snapshot' evaluations planned for 2013/14 and 2014/2015.

Infrastructure Monitoring 2012-2014:

- All DHBs will submit a self audit in 2013 and 2014. External evaluators will provide comment on self audit documents.
- External audits will be conducted at four DHBs identified with development and sustainability risks in 2013.
- External audits will be conducted in two randomly selected DHBs in 2014. This spot-check will assess quality of self auditing.

Internal Quality Monitoring of Programme Delivery:

- Standards and resources for VIP will be reviewed and refined in 2012.
- Workforce training in quality improvement will be provided to VIP staff focusing on standardised methods, data reliability and the Model of Improvement.[31]
- Standardised 'snapshot' data will be collated nationally in 2013 and 2014.

VIP PRIORITIES FOR 2012-2015

Evaluation activities will support VIP priorities for 2012 to 2015. These priorities include the following:

- Improving identification, assessment and responses to vulnerable children and their families/whānau
- Improving service delivery for women, children and whānau experiencing family violence evidenced by quality improvement data
- Supporting integration of safety planning for vulnerable families across primary, community and acute health services
- Contributing to better integration across health and social services for vulnerable families
- Supporting government priorities to reduce assaults on children by 2017
- Increasing the number of DHBs that have implemented National Child Protection Alert Systems
- Supporting DHB implementation of Shaken Baby Prevention Programmes
- Further development of DHB Whānau Ora Workforce Development activities that improve VIP responsiveness to Māori
- Supporting DHB implementation of elder abuse and neglect programmes

Strengths and Limitations

Strengths of this evaluation project include using established family violence programme evaluation instruments[2,18,32] and following standard quality improvement processes in auditing.[31,33] The project promotes a comprehensive systems approach to addressing family violence, a key characteristic for delivering effective services.[19,21,32]

Our processes of audit planning, site visits and reporting facilitate DHB VIP programme development over time. The evaluation project is also integrated in the VIP management programme, providing the Ministry the ability to target remedial actions in the context of limited resources. Development and implementation of the *VIP Quality Improvement Toolkit* and financial and technical support for DHB Whānau Ora initiatives are two such examples. The repeated audit rounds also foster a sense of urgency,[34] supporting timely policy revisions, procedure endorsements and filling of FVIC positions. Finally, and perhaps most importantly, the longitudinal nature of the evaluation has allowed monitoring of change over time (2004 to 2012).

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 acute hospital and community services of secondary and tertiary public hospitals provided by DHBs. 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.

- 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'.

- As the VIP programme has evolved, some indicators become 'out of date', such as the partner abuse programme tool requiring monthly (rather than quarterly) governance (steering group) meetings. While we might have altered the tool over time, we chose to hold the tool constant for the sake of comparisons over time.

- Finally, the VIP audit does not include indicators related to the *Family Violence Intervention Guidelines: Elder Abuse and Neglect*,[35] although an increasing number of DHBs have endorsed policies addressing elder abuse and neglect assessment and intervention (n=12 DHBs, 60%).

Conclusions

New Zealand DHBs have continued to make significant progress in developing systems for responding to women and children at risk for ongoing exposure to family violence. All DHBs have achieved the benchmark target score in both their partner abuse and child abuse and neglect programmes at 30 June 2012, exceeding the 2012 MOH goal of 90%.

The majority of DHB Violence Intervention Programmes have policies and procedures in place, good leadership and governance and established 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 Family Violence Intervention Coordinators. While programmes are doing well overall, there are still significant gaps.

The most important programme development need continues to be internal quality improvement activities. Evaluation activities have increased over time, supported by the *VIP Quality Improvement Toolkit*. Yet, furthering the scope of activities, improving measurement rigour and translating internal audit information into VIP quality improvements are areas for further attention. And while VIP Cultural Responsiveness scores continue to increase over time, Whānau Ora training activities to improve VIP responsiveness to Māori are still needed.

Aside from programme system developments, implementation of the Ministry's Family Violence Intervention Guidelines: Child and Partner Abuse[3] (*The Guidelines*) across target services is still in progress. Many DHBs have yet to roll out their VIP to all targeted services. For those implementing *The Guidelines,* increasing service delivery and quality continues to present challenges. Leadership, coordination, quality monitoring and evaluation activities are all elements required to enhance programme integration and inter-sectoral collaboration.

REFERENCES

1. Koziol-McLain J, Garrett N, Gear C. *Hospital Responsiveness to Family Violence: 48 Month Follow-Up Evaluation Report*: Interdisciplinary Trauma Research Unit, Auckland University of Technology;2009. 8.
2. Wilson D, Koziol-McLain J, Garrett N, Sharma P. A hospital-based child protection programme evaluation instrument: A modified Delphi study. *International Journal for Quality in Health Care.* Aug 2010;22(4):283-293.
3. Fanslow J. *Family Violence Intervention Guidelines: Child and Partner Abuse.* Wellington, New Zealand: Ministry of Health;2002.
4. Hau'alofa'ia Koloto A. *The Needs of Pacific Peoples When They Are Victims of Crime.* Wellington, New Zealand: Ministry of Justice;2003.
5. Ellsberg M. Violence against women and the Millennium Development Goals: Facilitating women's access to support. *Int J Gynaecol Obstet.* Sep 2006;94(3):325-332.
6. World Health Organisation. *Preventing child maltreatment: a guide to taking action and generating evidence*. Geneva, Switzerland: WHO; 2006.
7. Balzer R, Haimona D, Henare M, Matchitt V. *Maori Family Violence in Aotearoa.* Wellington, New Zealand: Te Puni Kokiri (Ministry of Maori Affairs);1997.
8. Fanslow J, Robinson E. Violence against women in New Zealand: prevalence and health consequences. *N Z Med J.* 2004;117(1206):U1173.
9. Morris A, Reilly J, Berry S, Ransom R. *New Zealand National Survey of Crime Victims 2001.* Wellington: Ministry of Justice;2003.
10. Young W, Morris A, Cameron N, Haslett S. *New Zealand National Survey of Crime Victims 1996.* Wellington, New Zealand: Victimisation Survey Committee;1997.
11. Morris A. *Women's Safety Survey 1996.* Wellington, New Zealand: Victimisation Survey Committee;1997.
12. Ministry of Health. *The New Zealand Health Strategy.* Wellington, New Zealand: Ministry of Health;2000.
13. Taskforce for Action on Violence Within Families. *The First Report.* Wellingon, New Zealand: Ministry of Social Development;2006.
14. Koziol-McLain J, Gear C, Garrett N. *Hospital Responsiveness to Family Violence: 84 Month Follow-Up Evaluation.* Auckland, NZ: Interdisciplinary Trauma Research Centre, Auckland University of Technology;2011. 1177-4347 Report No 10.
15. Karapetrovic S, Willborn W. Self-audit of process performance. *International Journal of Quality & Reliability Management.* 2002;19(1):24-45.
16. Karapetrovic S, Willborn W. Audit and self-assessment in quality management: comparison and compatibility. *Managerial Auditing Journal.* 2001;16(6):366-377.
17. Agency for Health Care Research and Quality. Evaluating Domestic Violence Programs. 2002; http://www.ahrq.gov/research/domesticviol. Accessed 10 May,2004.
18. Coben J. Measuring the quality of hospital-based domestic violence programs. *Acad Emerg Med.* Nov 2002;9(11):1176-1183.
19. McCaw B, Berman WH, Syme SL, Hunkeler EF. Beyond screening for domestic violence: a systems model approach in a managed care setting. *Am J Prev Med.* Oct 2001;21(3):170-176.
20. Wills R, Ritchie M, Wilson M. Improving detection and quality of assessment of child abuse and partner abuse is achievable with a formal organisational change approach. *Journal of Paediatrics and Child Health.* 2008;44(3):92-98.
21. O'Campo P, Kirst M, Tsamis C, Chambers C, Ahmad F. Implementing successful intimate partner violence screening programs in health care settings: Evidence generated from a realist-informed systematic review. *Social Science and Medicine.* Mar 2011;72(6):855-866.
22. Gear C, Koziol-McLain J, Wilson D. Cultural responsiveness to family violence in Aotearoa New Zealand District Health Boards: Interdisciplinary Trauma Research Centre, Auckland University of Technology; 2011.

23. Feder GS, Hutson M, Ramsay J, Taket AR. Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies. *Arch Intern Med.* 2006;166(1):22-37.

24. Spangaro JM, Zwi AB, Poulos RG, Man WY. Who tells and what happens: disclosure and health service responses to screening for intimate partner violence. *Health Soc Care Community.* Nov 2010;18(6):671-680.

25. Koziol-McLain J, Giddings L, Rameka M, Fyfe E. Intimate partner violence screening and brief intervention: experiences of women in two New Zealand Health Care Settings. *J Midwifery Womens Health.* 2008;53(6):504-510.

26. Ministry of Justice. *The New Zealand Crime and Safety Survey: 2009.* Wellington NZ: Ministry of Justice;2010.

27. Black MC, Breiding MJ. Adverse health conditions and health risk behaviors associated with intimate partner violence--United States, 2005. *MMWR Morb Mortal Wkly Rep.* Feb 8 2008;57(5):113-117.

28. Campbell JC. Health consequences of intimate partner violence. *Lancet.* 2002;359(9314):1331-1336.

29. Louwers EC, Korfage IJ, Affourtit MJ, et al. Detection of child abuse in emergency departments: a multi-centre study. *Archives of Disease in Childhood.* May 2011;96(5):422-425.

30. Benger JR, Pearce V. Simple intervention to improve detection of child abuse in emergency departments. *BMJ.* Mar 30 2002;324(7340):780.

31. Langley GL, Nolan KM, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. 2nd ed. San Francisco: Jossey-Bass Publishers; 2009.

32. Coben JH, Fisher EJ. Evaluating the implementation of hospital-based domestic violence programs. *Family Violence Prevention and Health Practice.* 2005;1(2):1-11.

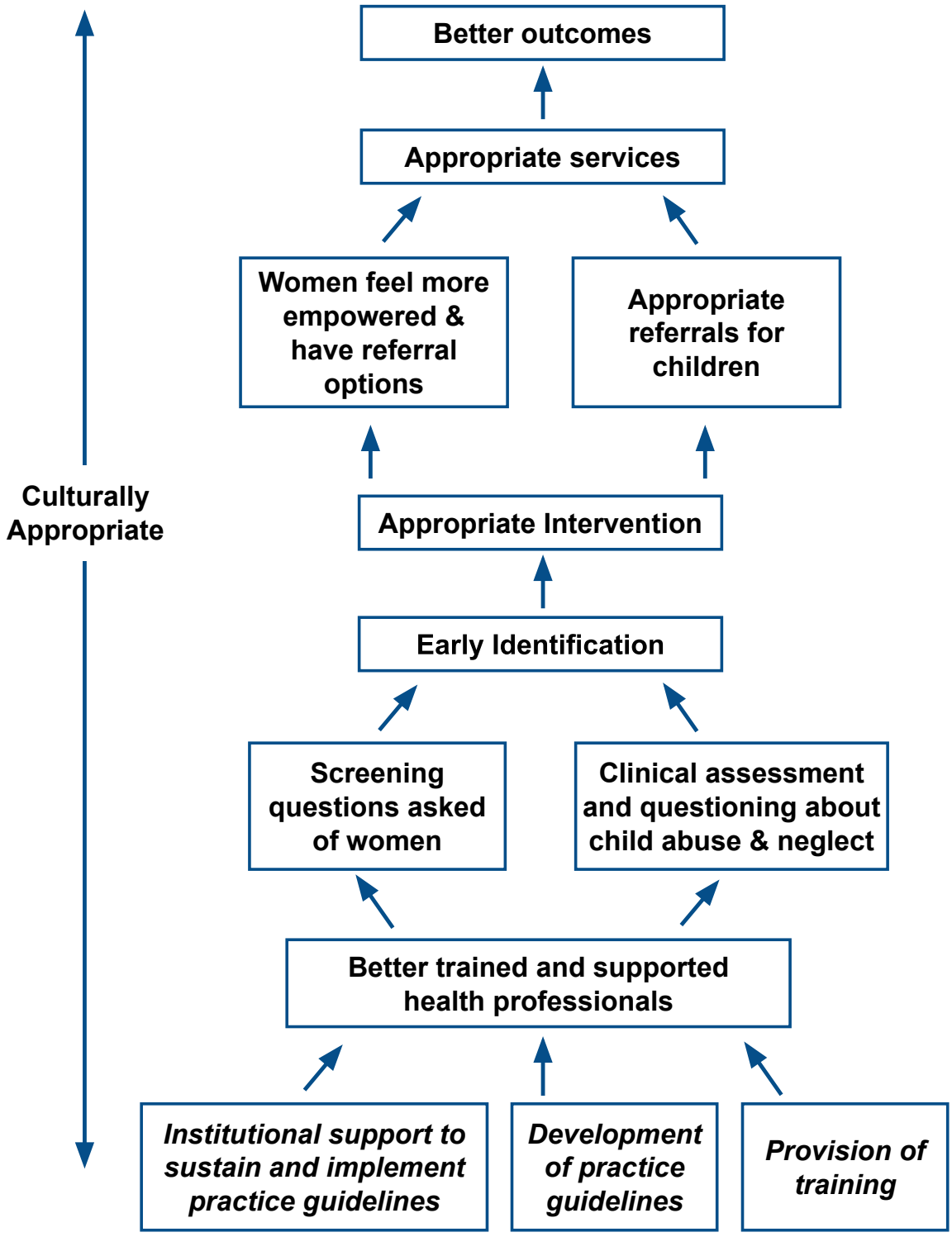
33. Karapetrovic S, Willborn W. Audit system: Concepts and practices. *Total Quality Management.* 2001;12(1):13 - 28.

34. Kotter JP. *Leading Change*. Boston: Harvard Business School Press; 1996.

35. Glasgow K, Fanslow J. *Family Violence Intervention Guidelines: Elder Abuse and Neglect.* Wellington: Ministry of Health;2006.

APPENDICES

APPENDIX A: Family Violence Project Programme Logic [4]



[4] 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: DHB Programme Information Form

Violence Intervention Programme Evaluation

96 Month Follow-up Audit

Programme Information Form

DHB Information:

Please complete:

DHB:

Hospital(s):

Self Audit Due Date:

External Audit Site Visit Date *(if applicable)*:

Please enter relevant name, position, and department:

DHB CEO:

DHB Funding & Planning Manager:

DHB VIP Sponsor (person with VIP signing authority):

DHB Audit contact details:

Name:

Title:

Phone/Mobile:

E-Mail:

1. Coordinator Status

Please complete the following for all persons in your DHB who have a dedicated Family Violence Intervention Coordination role at the date of this audit. Please include others who have been in the role since the last audit, but not currently. Coordinators may have primary responsibility for child abuse and neglect (CAN), partner abuse (PA), or both ('dual').

	Name	FTE	PA/CAN/DUAL	Permanent/Fixed	Start Date	End Date	Reports to
1							
2							
3							
4							
5							

2. Additional VIP Support Positions

Please list any additional dedicated VIP programme support positions and FTE funded by the DHB or other agencies (e.g. EAN, Primary Care, CYF Social Worker)

	Name	VIP FTE	Position Title	Responsibility	Permanent/Fixed	Reports to
1						
2						
3						
4						
5						

3. Wānau Ora Workforce Development

Please complete the following regarding VIP Whanau Ora initiatives undertaken.

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

4. National Training Package

Sign Off Date	Number of DHB employees trained in past 12 months	Training Provider	Comments
	Non-Clinical: *Clinical:*		

5. Elder Abuse

Does the DHB have policies on Older Adult/Elder Abuse?	YES/NO *(Delete one)*
Title: Date of Endorsement:	

6. Disability

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

7. Status Change

Has there been any significant DHB status change since the last audit that have affected VIP at this DHB? *Please elaborate (for example: changes in FVIC, programme sponsor, CEO, merger, restructuring):*	YES/NO (*Delete one)*

8. VIP Roll Out and Clinical Audit: Partner Abuse Screening

Service (note whether hospital in patient or community out patient service)	VIP Implementation[5] (tick YES or NO for each service)		Partner Abuse Screening Audit (enter data for most recent audit) *Refer to QIA Toolkit: VIP Partner Abuse Screening and Documentation Clinical Audit Tool*					
			Review Period Start	Review Period End	No. Eligible Records Reviewed	No. Screened	No. Disclosed	Comments
	YES	NO	dd/mm/yy	dd/mm/yy				
Emergency Department								
Child Health – In Patient								
Child Health – Community								
Child Health – Other:								
Maternity - In Patient								
Maternity – Community								
Sexual Health – Community								
Mental Health – In Patient								
Mental Health – Community								
Alcohol & Drug – Community								
Other (e.g., EAN, Primary Care, other Family/Whanau health services):								
Other:								

[5] Child Abuse and Neglect and Partner Abuse assessment and intervention.

9. 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)*

Does the DHB have a standardised child injury assessment documentation form (injury flow chart)? YES/NO *(Delete one)* What is the age of children included? _____ Years of age or less

	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						

10. Clinical Audit: Documentation audit of referrals made by DHB to Child Youth and Family (CYF)

(refer to QIA Toolkit: *Clinical audit of Violence Intervention Programm; 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

11. Child Protection Interagency MOU between Child Youth and Family, New Zealand Police and DHB

Sign Off Date	Comments (please note local schedules to the MOU)

12. National Child Protection Alert participation status

Sign Off Date	Comments

13. VIP strategic planning documents

	Title (time period)	Sign Off Date	Comments
Programme Strategic Plan			
Training Plan			
Quality Improvement Plan			
Other			

14. Most significant VIP achievements since the last audit:

15. Programme Strengths:

16. Recommendations for programme improvement:

17. Any other comments?

APPENDIX D: 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 E: 2011-2012 Audit Round Process

[Letterhead removed]

VIP AUDIT PREPARATION INFORMATION
Self and External Audits
96 Month Follow-Up Evaluation, 2011-2012

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. External auditor participation requires access only to DHB and hospital system-level information and materials. No patient data is required. The evaluation project is approved by the Multi-region Ethics Committee (AKY/03/09/218 with current approval to 8 December 2012).

Audit Preparation
In recognition of increasing programme maturity nationally, DHBs are being supported in transitioning to VIP self audit. This transition aims to increase evaluation transparency and build VIP leader quality improvement expertise.

We encourage specification of a Self Audit Plan to guide evaluation processes. The plan is ideally developed in collaboration with the DHB VIP manager, steering group and Family Violence Intervention Coordinator(s). Additional self audit resources are available to assist you in effective self auditing. These include:

- Self Audit Preparation notes
- 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.

Submitting Your Self Audit
Complete the following items:

- ❑ Programme Information Form (attached)
- ❑ Partner Abuse excel audit tool
- ❑ Child Abuse and Neglect excel audit tool

Please double-check all items have been answered and submit the above items to Claire Gear by your due date. You will not be notified of any missing items.

Self audit indicator evidence:

- Collate and have available (Ministry may choose to spot check evidence).
- Reference in the respective 'evidence' columns of the excel audit tools
- **Do not** submit evidence (such as policies and procedures) with the self-audit

External Audit Preparation (one day on-site visit)

- ❑ Have indicator evidence (as prepared for the self audit) available for viewing by the external evaluator
- ❑ Submit audit day itinerary (see below) and finalise with Claire Gear

Reporting

Self Audit Report. We encourage all DHBs to develop site-specific VIP audit reports, based on self audit results. A report template is available on HIRRC to assist this process. You are not required to submit this report to AUT if you are also having an external audit.

External Audit Report.

1. FVICs will receive a draft audit report approximately two weeks following the external audit including child abuse and neglect, partner abuse and cultural responsiveness programme scores, self audit scores, summary, recommendations.
2. FVICs 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 July 2012. **Confidentiality: 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, however, will identify DHBs (e.g., in league tables).**

Audit Support

Audit support is available through various means. Regional FVICs may be the first point of contact. FVIC, particularly those new to the role, are encouraged to discuss audit preparation with the VIP National Manager. Please contact Claire Gear with queries about the audit tool or process. The Ministry of Health contact person is Sue Zimmerman. Please feel free to contact her in regards to the study on (09) 580 9145 or **Sue_Zimmerman@moh.govt.nz.**

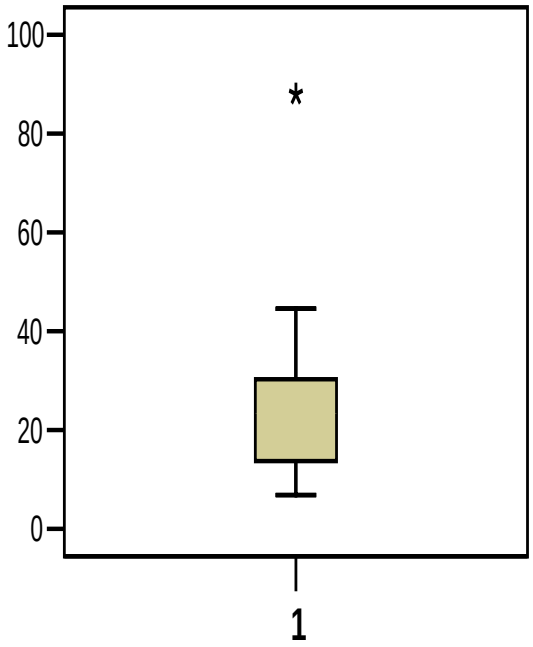
Concerns: For concerns regarding the process or conduct of the audit please contact Jane Koziol-McLain or Sue Zimmerman.

Research Team:

External audits will be conducted by Professor Jane Koziol-McLain, supported by Claire Gear.

Claire Gear, BSocSci (Hons) Research Officer Interdisciplinary Trauma Research Centre School of Health Care Practice Auckland University of Technology (09) 921 9999 x7152 claire.gear@aut.ac.nz	Professor Jane Koziol-McLain, PhD, RN Principal Investigator Interdisciplinary Trauma Research Centre School of Health Care Practice Auckland University of Technology (09) 921 9670 jkoziolm@aut.ac.nz

APPENDIX F: 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 G. Partner Abuse Baseline and Follow-Up Scores

	Hospital Median Scores							*Hospitals Achieving Target Score (≥70) n (%)*						
	B	***F_{12}***	***F_{30}***	***F_{48}***	***F_{60}***	F_{84}	***F_{96}***[c]	***B***	***F_{12}***	***F_{30}***[b]	***F_{48}***	***F_{60}***	***F_{84}***	***F_{96}***[c]
Overall Score	19.6	27.6	49.2	66.9	74.4	84.4	**91.3**	1 (4%)	2 (8%)	5 (19%)	13[a] (48%)	15 (56%)	25 (93%)	**27 (100%)**
Domain Scores														
Policies and Procedures	19.4	29.5	48.8	62.0	75.1	82.1	**86.8**	1 (4%)	2 (8%)	7 (26%)	11 (41%)	16 (59%)	20 (74%)	**24 (89%)**
Physical Environment	7.1	14.7	23.1	75.0	78.8	91.3	**100**	0 (0%)	1 (4%)	4 (15%)	16 (59%)	16 (59%)	23 (85%)	**25 (93%)**
Institutional Culture	22.1	30.7	59.0	72.4	83.4	88.9	**93.7**	2 (8%)	5 (20%)	8 (30%)	15 (56%)	16 (59%)	23 (85%)	**25 (93%)**
Training of Providers	10.9	31.9	58.7	78.2	88.4	89.1	**100**	1 (4%)	5 (20%)	8 (30%)	15 (56%)	18 (67%)	26 (96%)	**26 (96%)**
Screening and Safety Assessment	0.0	0.0	42.5	65.3	73.2	80.3	**80.3**	1 (4%)	2 (8%)	5 (19%)	13 (48%)	15 (56%)	18 (67%)	**22 (82%)**
Documentation	0.0	19.1	28.6	66.6	76.1	90.4	**90.5**	0 (0%)	0 (0%)	2 (7%)	12 (44%)	14 (52%)	22 (82%)	**24 (89%)**
Intervention Services	26.4	45.7	62.1	65.0	79.2	92.8	**100**	4 (16%)	6 (24%)	9 (33%)	11 (41%)	17 (63%)	24 (89%)	**27 (100%)**
Evaluation Activities	0.0	0.0	20.0	34.4	63.2	66.4	**80.0**	1 (4%)	1 (4%)	4 (15%)	6 (22%)	11 (41%)	13 (48%)	**23 (85%)**
Collaboration	37.5	77.1	78.5	93.0	91.6	100.0	**100**	1 (4%)	15 (60%)	19 (70%)	23 (85%)	25 (93%)	27 (100%)	**27 (100%)**

Notes: ***B*** =Baseline; ***F_{12}*** =12 month follow-up; ***F_{30}*** = 30 month follow-up; ***F_{48}*** = 48 month follow-up; ***F_{60}*** =60 month follow-up; ***F_{84}*** = 84 month follow-up; F_{96} =96 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 external scores (n=13 hospitals) and self audit scores (n=14 hospitals).

APPENDIX H: Partner Abuse Delphi Item Analysis

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

	"YES" responses	84 mo FU n (%)	96 mo FU n (%)
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:	26 (96%)	**27 (100%)**
	a) define partner abuse?	26 (96%)	**27 (100%)**
	b) mandate training on partner abuse for any staff?	26 (96%)	**27 (100%)**
	c) advocate universal screening for women anywhere in the hospital?	26 (96%)	**27 (100%)**
	d) define who is responsible for screening?	26 (96%)	**27 (100%)**
	e) address documentation?	26 (96%)	**27 (100%)**
	f) address referral of victims?	26 (96%)	**27 (100%)**
	g) address legal reporting requirements?	26 (96%)	**26 (96%)**
	h) address the responsibilities to, and needs of, Māori?	26 (96%)	**27 (100%)**
	i) address the needs of other (non-Māori/non-Pakeha) cultural and/or ethnic groups?	26 (96%)	**25 (93%)**
	k) address the needs of LGBT clients?	19 (70%)	**24 (89%)**
1.2	Is there evidence of a hospital-based partner abuse working group? If yes, does the group:	27 (100%)	**27 (100%)**
	a) meet at least every month?	8 (30%)	**11 (41%)**
	b) include representative(s) from more than two departments?	27 (100%)	**27 (100%)**
	c) include representative(s) from the security department?	18 (67%)	**21 (78%)**
	d) include physician(s) from the medical staff?	24 (89%)	**26 (96%)**
	e) include representative(s) from a partner abuse advocacy organization (eg., Women's Refuge)?	25 (93%)	**25 (93%)**
	f) include representative(s) from hospital administration?	27 (100%)	**27 (100%)**
	g) include Māori representative(s)?	27 (100%)	**27 (100%)**
1.3	Does the hospital provide direct financial support for the partner abuse programme (beyond VIP funding)?	22 (81%)	**21 (78%)**
1.3_a	Is funding set aside specifically for Māori programmes and initiatives?	13 (48%)	**15 (56%)**
1.4	Is there a mandatory universal screening policy in place?	26 (96%)	**27 (100%)**
1.5	Are there quality assurance procedures in place to ensure partner abuse screening?	23 (85%)	**27 (100%)**
	a) regular chart audits to assess screening?	23 (85%)	**26 (96%)**

	"YES" responses	84 mo FU n (%)	96 mo FU n (%)
	b) positive reinforcers to promote screening?	22 (82%)	**25 (93%)**
	c) is there regular supervision?	12 (44%)	**24 (89%)**
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?	12 (44%)	**18 (67%)**
	b) procedures that include name/phone block for victims admitted to hospital?	20 (74%)	**21 (78%)**
	c) procedures that include provisions for safe transport from the hospital to shelter?	17 (63%)	**23 (85%)**
	d) do these procedures take into account the needs of Māori?	13 (48%)	**14 (52%)**
1.7	Is there an identifiable partner abuse coordinator at the hospital? If yes is it a: (*choose one*)	27 (100%)	**27 (100%)**
	a) part time position or included with other responsibilities?	13 (48%)	**8 (30%)**
	b) full-time position with no other responsibilities?	14 (52%)	**19 (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	1 (4%)	**3 (11%)**
	21-35	26 (96%)	**24 (89%)**
	In how many locations are there Māori images related to partner abuse on display? (up to 17):		
	1-10	1 (4%)	**0 (0%)**
	11-17	26 (96%)	**27 (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%)	**3 (11%)**
	21-35	23 (85%)	**24 (89%)**
	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	4 (15%)	**1 (4%)**
	11-17	23 (85%)	**26 (96%)**
	In how many locations is there referral information re non- Māori non-Pakeha on public display? (up to 17)		
	0-6	6 (22%)	**4 (16%)**
	7-17	21 (78%)	**23 (84%)**
2.3	Does the hospital provide temporary (<24 hours) safe shelter for victims of partner abuse who cannot go home or cannot be placed in a community-based shelter? If yes:	20 (74%)	**24 (89%)**

	"YES" responses	84 mo FU n (%)	96 mo FU n (%)
	d) Does the design and use of the safe shelter support Māori cultural beliefs and practices?	18 (67%)	**22 (82%)**
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	26 (96%)	**27 (100%)**
	b) medical staff	19 (70%)	**24 (89%)**
	c) administration	19 (70%)	**20 (74%)**
	d) other staff/employees	25 (93%)	**27 (100%)**
	If yes, did the assessment address staff knowledge and attitude about Māori and partner abuse?	17 (63%)	**25 (93%)**
3.2	How long has the hospital's partner abuse programme been in existence?		
	1-24 months	3 (11%)	**0 (0%)**
	24-48 months	5 (19%)	**5 (19%)**
	>48 months	19 (70%)	**22 (81 %)**
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?	25 (93%)	**24 (89%)**
	b) Does the Employee Assistance programme (or equivalent) maintain specific policies and procedures for dealing with employees experiencing partner abuse?	12 (44%)	**12 (44%)**
	c) Is the topic of partner abuse among employees covered in the hospital training sessions and/or orientation?	25 (93%)	**27 (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?	26 (96%)	**27 (100%)**
	b) Are cultural issues discussed in the hospital's partner abuse training programme?	25 (93%)	**27 (100%)**
	c) Are translators/interpreters available for working with victims if English is not the victim's first language?	27 (100%)	**27 (100%)**
	d) Are referral information and brochures related to partner abuse available in languages other than English?	27 (100%)	**27 (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*)	27 (100%)	**25 (93%)**
	a) 1 programme in the last 12 months?	0 (0%)	**1 (4%)**
	b) >1 programme in the last 12 months?	27 (100%)	**24 (89%)**
	c) Does the hospital collaborate with Māori community organizations and providers to deliver preventive outreach and public education activities?	24 (89%)	**24 (89%)**
CATEGORY 4. TRAINING OF PROVIDERS			
4.1	Has a formal training plan been developed for the institution? If yes:	25 (93%)	**27 (100%)**
	a) Does the plan include the provision of regular, ongoing education for clinical staff?	26 (96%)	**27 (100%)**

	"YES" responses	**84 mo FU n (%)**	**96 mo FU n (%)**
	b) Does the plan include the provision of regular, ongoing education for non-clinical staff?	21 (78%)	**25 (93%)**
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?	26 (96%)	**27 (100%)**
	b) to members of the clinical staff via colloquia or other sessions?	27 (100%)	**27 (100%)**
4.3	Does the hospital's training/education on partner abuse include information about:		
	a) definitions of partner abuse?	25 (93%)	**27 (100%)**
	b) dynamics of partner abuse?	27 (100%)	**27 (100%)**
	c) epidemiology?	27 (100%)	**27 (100%)**
	d) health consequences?	27 (100%)	**27 (100%)**
	e) strategies for screening?	24 (89%)	**27 (100%)**
	f) risk assessment?	27 (100%)	**27 (100%)**
	g) documentation?	23 (85%)	**27 (100%)**
	h) intervention?	25 (93%)	**27 (100%)**
	i) safety planning?	24 (89%)	**27 (100%)**
	j) community resources?	25 (93%)	**27 (100%)**
	k) reporting requirements?	27 (100%)	**27 (100%)**
	l) legal issues?	27 (100%)	**27 (100%)**
	m) confidentiality?	27 (100%)	**27 (100%)**
	n) cultural competency?	26 (96%)	**27 (100%)**
	o) clinical signs/symptoms?	24 (89%)	**27 (100%)**
	p) Māori models of health?	23 (85%)	**27 (100%)**
	q) risk assessment for children of victims?	27 (100%)	**27 (100%)**
	r) social, cultural, historic, and economic context in which Māori family violence occurs?	22 (82%)	**27 (100%)**
	s) te Tiriti o Waitangi?	23 (85%)	**27 (100%)**
	t) Māori service providers and community resources?	24 (89%)	**27 (100%)**
	u) service providers and community resources for ethnic and cultural groups other than Pakeha and Māori?	23 (85%)	**27 (100%)**
	v) partner abuse in same-sex relationships?	25 (93%)	**27 (100%)**
	w) service providers and community resources for victims of partner abuse who are in same-sex relationships?	19 (70%)	**26 (96%)**
4.4	Is the partner abuse training provided by: (*choose one a-d and answer e-f*)		
	b) a single individual?	0 (0%)	**1 (4%)**
	c) a team of hospital employees only?	1 (4%)	**0(0%)**
	d) a team, including community expert(s)?	26 (96%)	**26 (96%)**
	If provided by a team, does it include:		

	"YES" responses	84 mo FU n (%)	96 mo FU n (%)
	e) a Māori representative?	25 (93%)	**26 (96%)**
	f) a representative(s) of other ethnic/cultural groups?	13 (48%)	**23 (85%)**
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 yes,	27 (100%)	**27 (100%)**
	a) included, as a separate form, in the clinical record?	0 (0%)	**1 (4%)**
	b) incorporated as questions in the clinical record for all charts in ED or other out-patient area?	4 (15%)	**0 (0%)**
	c) incorporated as questions in the clinical record for all charts in two or more out-patient areas?	16 (59%)	**17 (63%)**
	d) incorporated as questions in clinical record for all charts in out-patient and in-patient areas?	7 (26%)	**9 (33%)**
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	5 (19%)	**0 (0%)**
	0% - 10%	2 (8%)	**5 (18%)**
	11% - 25%	5 (19%)	**2 (8%)**
	26% - 50%	9 (33%)	**11 (41%)**
	51% - 75%	6 (22%)	**6 (22%)**
	76% - 100%	0 (%)	**3 (11%)**
5.3	Is a standardized safety assessment performed and discussed with victims who screen positive for partner abuse? If yes, does this:	26 (96%)	**27 (100%)**
	a) also assess the safety of any children in the victim's care?	26 (96%)	**27 (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:	27 (100%)	**26 (96%)**
	a) information on the results of partner abuse screening?	27 (100%)	**26 (96%)**
	b) the victim's description of current and/or past abuse?	19 (70%)	**24 (89%)**
	c) the name of the alleged perpetrator and relationship to the victim?	18 (67%)	**24 (89%)**
	d) a body map to document injuries?	21 (78%)	**23 (85%)**
	e) information documenting the referrals provided to the victim?	26 (96%)	**26 (96%)**
	f) in the case of Māori, information documenting whether the individual was offered a Māori advocate?	19 (70%)	**25 (93%)**
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%)	**25 (93%)**
	b) Do hospital staff receive on-going training on the use of the camera?	21 (78%)	**18 (67%)**
	c) Do hospital staff routinely offer to photograph all abused patients with injuries?	11 (41%)	**16 (59%)**
	d) Is a specific, unique consent-to-photograph form obtained prior to photographing any injuries?	22 (82%)	**21 (78%)**

	"YES" responses	84 mo FU n (%)	96 mo FU n (%)
	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?	22 (82%)	**17 (63%)**
CATEGORY 7. INTERVENTION SERVICES			
7.1	Is there a standard intervention checklist for staff to use/refer to when victims are identified?	26 (96%)	**27 (100%)**
7.2	Are on-site victim advocacy services provided? If yes, *choose one a-b and answer c-d)*:	26 (96%)	**27 (100%)**
	a) A trained victim advocate provides services during certain hours.	7 (26%)	**4 (15%)**
	b) A trained victim advocate provides service at all times.	19 (70%)	**23 (85%)**
	c) is a Māori advocate is available on-site for Māori victims?	27 (100%)	**27 (100%)**
	d) is an advocate(s) of ethnic and cultural background other than Pakeha and Māori available onsite?	24 (89%)	**26 (96%)**
7.3	Are mental health/psychological assessments performed within the context of the programme? If yes, are they:	26 (96%)	**27 (100%)**
	a) available, when indicated?	0 (0%)	**4 (15%)**
	b) performed routinely?	26 (96%)	**23 (85%)**
7.4	Is transportation provided for victims, if needed?	18 (67%)	**24 (89%)**
7.5	Does the hospital partner abuse programme include follow-up contact and counselling with victims after the initial assessment?	19 (70%)	**26 (96%)**
7.6	Does the hospital partner abuse programme offer and provide on-site legal options counselling for victims?	23 (85%)	**27 (100%)**
7.7	Does the hospital partner abuse programme offer and provide partner abuse services for the children of victims?	26 (96%)	**27 (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?	26 (96%)	**27 (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:	27 (100%)	**26 (96%)**
	a) Do evaluation activities include periodic monitoring of charts to audit for partner abuse screening?	22 (82%)	**27 (100%)**
	b) Do evaluation activities include peer-to-peer case reviews around partner abuse?	23 (85%)	**26 (96%)**
8.2	Do health care providers receive standardized feedback on their performance and on patients?	15 (56%)	**22 (82%)**
8.3	Is there any measurement of client satisfaction and/or community satisfaction with the partner abuse programme?	17 (63%)	**21 (78%)**
8.4	Is a quality framework (such as Whanau Ora) used to evaluate whether services are effective for Māori?	10 (37%)	**10 (37%)**
CATEGORY 9. COLLABORATION			
9.1	Does the hospital collaborate with local partner abuse programmes? If yes,	27 (100%)	**27 (100%)**
	a i) collaboration with training?	26 (96%)	**26 (96%)**
	ii) collaboration on policy and procedure development?	27 (100%)	**27 (100%)**
	iii) collaboration on partner abuse working group?	25 (93%)	**25 (93%)**
	iv) collaboration on site service provision?	26 (96%)	**27 (100%)**

	"YES" responses	**84 mo FU n (%)**	**96 mo FU n (%)**
	b) is collaboration with		
	i) Māori provider(s) or representative(s)?	27 (100%)	**27 (100%)**
	iii) Provider(s) or representative(s) for ethnic or cultural groups other than Pakeha or Māori?	24 (89%)	**25 (93%)**
9.2	Does the hospital collaborate with local police and courts in conjunction with their partner abuse programme? If yes:	27 (100%)	**27 (100%)**
	a) collaboration with training?	25 (93%)	**26 (96%)**
	b) collaboration on policy and procedure development?	27 (100%)	**27 (100%)**
	c) collaboration on partner abuse working group?	24 (89%)	**25 (93%)**
9.3	Is there collaboration with the partner abuse programme of other health care facilities? If yes, which types of collaboration apply:	27 (100%)	**27 (100%)**
	a) within the same health care system?	27 (100%)	**27 (100%)**
	If yes, with a Māori health unit?	27 (100%)	**26 (96%)**
	b) with other systems in the region?	27 (100%)	**27 (100%)**
	If yes, with a Māori health provider?	26 (96%)	**26 (96%)**

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

	Median							*Hospitals Achieving Target Score ≥70*						
	B	***F_{12}***	***F_{30}***	***F_{48}***[a]	***F_{60}***	***F_{84}***	***F_{96}***[c]	***B***	***F_{12}***	***F_{30}***[b]	***F_{48}***[a]	***F_{60}***	***F_{84}***	***F_{96}***[c]
Overall Score	36.7	50.8	59.3	74.5	80.9	86.5	**90.8**	2 (8%)	3 (12%)	4 (15%)	17 (65%)	21 (78%)	25 (93%)	**27 (100%)**
Domain Scores														
Policies and Procedures	42.5	50.0	59.7	81.0	84.0	92.0	**95.0**	3 (12%)	5 (20%)	8 (29%)	23 (89%)	19 (70%)	26 (96%)	**27 (100%)**
Safety & Security	-	-	-	77.0	72.0	82.0	**90.0**	-	-	-	17 (65%)	17 (63%)	23 (85%)	**27 (100%)**
Collaboration	46.5	70.8	85.4	82.5	91.0	94.0	**97.0**	5 (20%)	15 (60%)	20 (74%)	21 (81%)	25 (93%)	26 (96%)	**27 (100%)**
Institutional Culture	41.5	43.4	56.6	80.0	82.0	86.0	**90.0**	3 (12%)	5 (20%)	6 (22%)	18 (69%)	20 (74%)	25 (93%)	**27 (100%)**
Training of Providers	39.7	49.4	66.7	92.5	96.0	98.0	**100.0**	2 (8%)	9 (36%)	14 (52%)	19 (73%)	22 (82%)	26 (96%)	**27 (100%)**
Intervention Services	65.4	70.4	72.8	82.0	84.0	89.0	**92.0**	12(48%)	13 (52%)	15 (56%)	21 (81%)	22 (82%)	27 (100%)	**27 (100%)**
Documentation	19.0	28.6	58.4	83.5	83.0	87.0	**93.0**	5 (20%)	5 (20%)	8 (29%)	22 (85%)	19 (70%)	22 (82%)	**24 (89%)**
Evaluation Activities	35.1	36.6	36.6	29.8	58.5	72.0	**75.5**	1 (4%)	1 (4%)	5 (19%)	3 (12%)	7 (26%)	14 (52%)	**18 (67%)**
Physical Environment	23.0	28.0	35.6	68.0	91.0	100.0	**100.0**	1 (4%)	2 (5%)	2 (7%)	12 (46%)	26 (96%)	27 (100%)	**27 (100%)**

Notes: ***B*** =Baseline; ***F_{12}*** =12 month follow-up; ***F_{30}*** = 30 month follow-up; ***F_{48}*** = 48 month follow-up; ***F_{60}*** = 60 month follow-up; ***F_{84}*** = 84 month follow-up; ***F_{96}*** =96 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 external scores (n=13 hospitals) and self audit scores (n=14 hospitals).

APPENDIX J: Revised Child Abuse and Neglect Delphi Tool Item Analysis

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

	"YES" responses	84 mo FU n (%)	96 mo FU n (%)
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:	26 (96%)	27 (100%)
	a) Define child abuse and neglect?	27 (100%)	27 (100%)
	b) Mandate training on child abuse and neglect for staff?	26 (96%)	25 (93%)
	c) Outline age-appropriate protocols for risk assessment?	20 (74%)	23 (85%)
	d) Define who is responsible for risk assessment?	27 (100%)	27 (100%)
	e) Address the issue of contamination during interviewing?	24 (89%)	24 (89%)
	f) Address documentation?	27 (100%)	27 (100%)
	g) Address referrals for children and their families?	27 (100%)	27 (100%)
	h) Address child protection reporting requirements?	27 (100%)	27 (100%)
	i) Address the responsibilities to, and needs of, Māori?	27 (100%)	27 (100%)
	j) Address other cultural and/or ethnic groups?	27 (100%)	26 (96%)
1.2	Who is consulted regarding child protection policies and procedures?		
	Maori and Pacific?	26 (96%)	27 (100%)
	CYF?	27 (100%)	27 (100%)
	Police?	24 (89%)	27 (100%)
	Child abuse and neglect programme and Violence Intervention Programme staff?	27 (100%)	27 (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)	25 (93%)	27 (100%)
1.3	Is there evidence of a DHB-based child abuse and neglect steering group? If yes, does the:		
	a) Steering group meet at least every three (3) months?	25 (93%)	26 (97%)
	b) Include representatives from more than two departments?	26 (96%)	27 (100%)
1.4	Does the DHB provide direct financial support for the child abuse and neglect programme (beyond VIP funding)?	25 (93%)	24 (89%)
	e) Is funding set aside specifically for Māori programmes and initiatives?	13 (48%)	19 (70%)
1.5	Is there a policy for identifying signs and symptoms of child abuse and neglect and for identifying children at high risk? d) in both inpatient and outpatient areas?	27 (100%)	27 (100%)

	"YES" responses	84 mo FU n (%)	96 mo FU n (%)
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%)	27 (100%)
	b) include name/phone block?	17 (63%)	21 (78%)
	c) provide for safe transportation?	19 (70%)	20 (74%)
	d) account for the needs of Māori?	16 (59%)	23 (85%)
1.7	Is there an identifiable child protection coordinator at the DHB? If yes, is the coordinator position (choose one):	26 (96%)	27 (100%)
	a) part-time <0.5 FTE	1 (4%)	1 (4%)
	a) part-time ≥0.5 FTE?	13 (48%)	8 (29%)
	b) full-time?	12 (44%)	18 (67%)
1.8	Are there policies that outline the minimum expectation for all staff:		
	a) to attend mandatory training?	26 (96%)	25 (93%)
	b) to identification and referral children at risk?	27 (100%)	27 (100%)
	c) to reporting child protection concerns?	25 (93%)	27 (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%)	27 (100%)
	b) community groups?	26 (96%)	27 (100%)
1.10	Are the DHB policies and procedures easily accessible and user-friendly? If yes, are	27 (100%)	27 (100%)
	a) they available on the DHB intranet?	27 (100%)	27 (100%)
	b) there supporting and reference documents appended to the appropriate policies and procedures?	27 (100%)	27 (100%)
	c) there translation materials to facilitate the application of policy and procedures, such as flowcharts and algorithms?	27 (100%)	27 (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%)	26 (96%)
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?	25 (93%)	27 (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:	26 (96%)	27 (100%)
	b) within the DHB?	27 (100%)	27 (100%)
	c) with other groups and agencies in the region?	26 (96%)	27 (100%)

	"YES" responses	84 mo FU n (%)	96 mo FU n (%)
	d) with Māori and Pacific health providers?	24 (89%)	27 (100%)
	e) with other relevant ethnic/cultural groups?	22 (82%)	24 (89%)
	f) with the primary health sector?	11 (41%)	21 (78%)
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%)	27 (100%)
	b) with relevant primary health care providers as part of discharge planning?	12 (44%)	19 (70%)
	c) by accessing necessary support services for the child and family to promote ongoing safety of the child?	22 (82%)	27 (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?	25 (93%)	27 (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	25 (93%)	24 (89%)
	c) a local alert system in community setting, including PHO	8 (30%)	6 (22%)
	d) a process for notification of alert placements to relevant providers	18 (67%)	15 (56%)
	e) participation in a national alert system	8 (30%)	13 (48%)
	f) clear criteria for identifying levels of risk, and process that guides the use of the alert system	18 (67%)	18 (67%)
2.6	Is there evidence in protocols of processes to assess or refer to CYF and/or other appropriate agencies all children		
	a) process that includes the safety of other children in the home are considered?	27 (100%)	26 (96%)
	b) process for notifying CYF and/or other agencies?	26 (96%)	26 (96%)
	c) referral form that requires the documentation of the risk assessed for these children?	13 (48%)	19 (70.4%)
	CATEGORY 3. COLLABORATION		
3.1	Does the DHB collaborate with CYF and NGO child advocacy and protection?	27 (100%)	27 (100%)
	a) which types of collaboration apply:		
	i) collaboration with training?	27 (100%)	27 (100%)
	ii) collaboration on policy and procedure development?	27 (100%)	27 (100%)
	iii) collaboration on child abuse and neglect task force?	27 (100%)	27 (100%)
	iv) collaboration on site service provision?	27 (100%)	27 (100%)
	v) collaboration is two-way?	27 (100%)	27 (100%)

	"YES" responses	84 mo FU n (%)	96 mo FU n (%)
	b) is collaboration with:		
	i) CYF?	27 (100%)	27 (100%)
	ii) NGOs and other agencies such as Women's Refuge?	27 (100%)	27 (100%)
	iii) Māori provider(s) or representative(s)?	27 (100%)	27 (100%)
	iv) Provider(s) or representative(s) for ethnic or cultural groups other than Pakeha or Māori?	25 (93%)	27 (100%)
	c) services, departments and between relevant staff within the DHB evident?	27 (100%)	27 (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%)	27 (100%)
	a) collaboration with training?	27 (100%)	27 (100%)
	b) collaboration on policy and procedure development?	26 (96%)	27 (100%)
	c) collaboration on child abuse and neglect task force?	26 (96%)	27 (100%)
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%)	27 (100%)
	a) within the DHB?	27 (100%)	27 (100%)
	b) with a Māori unit?	27 (100%)	27 (100%)
	c) with other groups and agencies in the region?	27 (100%)	27 (100%)
	d) with a Māori health provider?	24 (89%)	25 (93%)
	e) with the primary health care sector?	25 (93%)	27 (100%)
	f) with national network of child protection and family violence coordinators?	27 (100%)	27 (100%)
3.4	Do relevant staff have membership on, or attend:		
	a) the interdisciplinary child protection team?	27 (100%)	27 (100%)
	b) Child abuse team meetings?	27 (100%)	27 (100%)
	c) Sexual abuse team meetings?	25 (93%)	26 (96%)
	d) CYF Care and Protection Resource Panel?	24 (89%)	25 (93%)
	e) National Network of Family Violence Intervention Coordinators?	27 (100%)	27 (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?	22 (82%)	25 (93%)
	b) the Police?	20 (74%)	25 (93%)

	"YES" responses	84 mo FU n (%)	96 mo FU n (%)
3.6	Does the DHB have a Memorandum of Understanding or service agreement that enables timely medical examinations to support:		
	a) CYF?	15 (56%)	23 (85%)
	b) Police?	16 (59%)	23 (85%)
	c) DSAC?	14 (52%)	18 (67%)
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?	20 (74%)	21 (78%)
	b) child protection is in the DHB Annual Plan?	23 (85%)	26 (96%)
	c) the child protection programme is adequately resourced, including dedicated programme staff?	12 (44%)	19 (70%)
	d) a working group of skilled and trained people who operationalises policies and procedures, in addition to the child protection coordinator?	27 (100%)	27 (100%)
	e) attendance at training as a key performance indicator (KPI) for staff?	13 (48%)	16 (59%)
	f) roles of those in the child abuse and neglect working team are included in position descriptions?	19 (70%)	14 (52%)
	g) DHB representation on the CYF Care and Protection Resource Panel?	25 (93%)	25 (93%)
	h) the Child Protection Coordinator is supported to attend the VIP Coordinator Meetings?	27 (100%)	27 (100%)
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?	26 (96%)	27 (100%)
	a) nursing staff	26 (96%)	27 (100%)
	b) medical staff	20 (74%)	24 (89%)
	c) administration	17 (63%)	18 (67%)
	d) other staff/employees	24 (84%)	25 (93%)
	If yes, did the assessment address staff knowledge and attitude about Māori and child abuse and neglect?	15 (56%)	23 (85%)
4.3	How long has the hospital's child abuse and neglect programme been in existence?		
	b) 24-48 months	2 (7%)	1 (4%)
	c) >48 months	25 (93%)	26 (96%)
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%)	27 (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%)	27 (100%)
	b) Are cultural issues discussed in the hospital's child abuse and neglect training programme?	27 (100%)	25 (93%)

	"YES" responses	84 mo FU n (%)	96 mo FU n (%)
	d) are translators/interpreters available for working with victims if English is not the victim's first language?	27 (100%)	27 (100%)
	d) Are referral information and brochures related to child abuse and neglect available in languages other than English?	26 (96%)	23 (85%)
4.5	Does the DHB participate in prevention outreach/public education activities on the topic of child abuse and neglect?	27 (100%)	27 (100%)
	a) 1 programme in the last 12 months?	3 (11%)	1 (4%)
	b) >1 programme in the last 12 months?	24 (89%)	26 (96%)
	c) Does the DHB collaborate with Māori community organisations and providers to deliver preventive outreach and public education activities?	25 (93%)	19 (70%)
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?	23 (85%)	25 (93%)
	b) is a list of supportive interventions available?	20 (74%)	27 (100%)
	c) are staff aware of how to access support and interventions available?	23 (85%)	27 (100%)
4.7	Is there evidence of coordination between the DHB child abuse and neglect programme in collaboration with other violence intervention programmes?	27 (100%)	27 (100%)
	b) is there is a referral mechanism?	26 (96%)	27 (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?	21 (78%)	25 (93%)
	b) a list of translators is accessible?	26 (96%)	26 (96%)
	c) translators used that are gender and age appropriate?	16 (59%)	18 (67%)
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?	19 (70%)	26 (96%)
	b) access to child abuse and neglect training?	22 (82%)	26 (96%)
	c) coordination of referral processes between the DHB and primary health care sectors?	13 (48%)	20 (74%)
	d) ongoing relationships and activities that focus on prevention and promoting child protection?	23 (85%)	25 (93%)
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?	25 (93%)	26 (96%)
	b) an operational plan that outlines the specifics of the programme of training?	25 (93%)	27 (100%)
	c) Does the plan include the provision of regular, ongoing education for clinical staff?	25 (93%)	27 (100%)
	d) Does the plan include the provision of regular, ongoing education for non-clinical staff?	22 (82%)	25 (93%)

	"YES" responses	**84 mo FU n (%)**	**96 mo FU n (%)**
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%)	27 (100%)
	b) to members of the clinical staff via colloquia or other sessions?	27 (100%)	27 (100%)
5.3	Does the training/education on child abuse and neglect include information about:		
	a) definitions of child abuse and neglect?	27 (100%)	27 (100%)
	b) dynamics of child abuse and neglect?	27 (100%)	27 (100%)
	c) child advocacy?	25 (93%)	27 (100%)
	d) appropriate child-centred interviewing?	26 (96%)	26 (96%)
	e) issues of contamination?	27 (100%)	27 (100%)
	f) ethical dilemmas?	26 (96%)	27 (100%)
	g) conflict of interest?	25 (93%)	27 (100%)
	h) epidemiology?	27 (100%)	27 (100%)
	i) health consequences?	26 (96%)	25 (93%)
	j) identifying high risk indicators?	27 (100%)	27 (100%)
	k) physical signs and symptoms?	27 (100%)	27 (100%)
	l) dual assessment with partner violence?	26 (96%)	27 (100%)
	m) documentation?	27 (100%)	27 (100%)
	n) intervention?	27 (100%)	27 (100%)
	o) safety planning?	26 (96%)	27 (100%)
	p) community resources?	26 (96%)	27 (100%)
	q) child protection reporting requirements?	27 (100%)	27 (100%)
	r) linking with the police and child youth and family?	27 (100%)	27 (100%)
	s) limits of confidentiality?	27 (100%)	27 (100%)
	t) age appropriate assessment and intervention?	25 (93%)	27 (100%)
	u) cultural issues?	26 (96%)	27 (100%)
	v) link between partner violence and child abuse and neglect?	27 (100%)	27 (100%)
	w) Māori models of health?	21 (78%)	24 (89%)
	x) the social, cultural, historic, and economic context in which Māori family violence occurs?	22 (82%)	23 (85%)
	y) Te Tiriti o Waitangi?	23 (85%)	26 (96%)
	z) Māori service providers and community resources?	25 (93%)	27 (100%)
	aa) service providers and community resources for ethic and cultural groups other than Pakeha and Māori?	23 (85%)	27 (100%)
	ab) If all sub-items are evident, bonus 1.5	18 (67%)	20 (74%)

	"YES" responses	84 mo FU n (%)	96 mo FU n (%)
5.4	Is the child abuse and neglect training provided by: (*choose one of a-d and answer e-f)*		
	c) a team of DHB employees only?	1 (4%)	0 (0%)
	d) a team, including community expert(s)?	26 (96%)	27 (100%)
	e) a Child Youth and Family statutory social worker?	26 (96%)	27 (100%)
	f) a Māori representative?	26 (96%)	26 (96%)
	g) a representative(s) of other ethnic/cultural groups?	16 (59%)	22 (82%)
5.5	Is the training delivered in collaboration with various disciplines, and providers of child protection services, such as CYF, Police and community agencies?	26 (96%)	27 (100%)
5.6	Does the plan include a range of teaching and learning approaches used to deliver training on child abuse and neglect?	26 (96%)	27 (100%)
CATEGORY 7. 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%)	27 (100%)
6.2	Are child protection services available "on-site"? If yes, *choose one of a-b and answer c-d*:	27 (100%)	27 (100%)
	a) A member of the child protection team or social worker provides services during certain hours.	5 (19%)	3 (11%)
	b) A member of the child protection team or social worker provides service at all times.	22 (82%)	24 (89%)
	c) A Māori advocate or social worker is available "on-site" for Māori victims.	27 (100%)	26 (96%)
	d) An advocate of ethnic and cultural background other Pakeha and Māori is available onsite.	17 (63%)	23 (85%)
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%)	27 (100%)
	a) available, when indicated?	18 (67%)	11 (41%)
	b) performed routinely?	9 (33%)	16 (59%)
	c) age-appropriate?	26 (96%)	27 (100%)
6.4	Do the intervention services include:		
	a) access to physical and sexual examination?	27 (100%)	27 (100%)
	b) access to specialised sexual abuse services?	27 (100%)	27 (100%)
	c) family focused interventions?	24 (89%)	27 (100%)
	d) support services that include relevant NGOs, or acute crisis counsellors/support?	27 (100%)	27 (100%)
	e) culturally appropriate advocacy and support?	27 (100%)	27 (100%)
6.5	Are Social Workers available?		
	a) Monday to Friday 8 am to 4 pm service, with referrals outside of these hours?	15 (56%)	16 (59%)
	b) 0n-call after 4 pm and at weekends?	3 (11%)	3 (11%)
	c) as a 24 hour service?	9 (33%)	8 (30%)

	"YES" responses	84 mo FU n (%)	96 mo FU n (%)
6.6	Is there a current list of relevant services available to support child and family safety?	25 (93%)	27 (100%)
6.7	Is provision made for transport for victims and their families, if needed?	23 (85%)	24 (89%)
6.8	Does the DHB child abuse and neglect programme include follow-up contact and counselling with victims after the initial assessment?	22 (82%)	27 (100%)
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%)	26 (96%)
	b) siblings	27 (100%)	26 (96%)
6.10	Is there evidence of coordination with CYF and the Police for children identified at risk of child abuse and neglect?	27 (100%)	27 (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:	27 (100%)	26 (96%)
	a) Reason for presentation?	27 (100%)	26 (96%)
	a) information generated by risk assessment?	21 (78%)	25 (93%)
	b) the victim or caregiver's description of current and/or past abuse?	22 (82%)	26 (96%)
	c) the name of the alleged perpetrator and relationship to the victim?	13 (48%)	21 (78%)
	d) a body map to document injuries?	19 (70%)	25 (93%)
	f) Past medical history?	19 (70%)	22 (82%)
	g) A social history, including living circumstances?	13 (48%)	24 (89%)
	h) An injury assessment, including photographic evidence (if appropriate)?	19 (70%)	23 (85%)
	i) The interventions undertaken?	19 (70%)	23 (85%)
	e) information documenting the referrals provided to the victim and their family?	19 (70%)	21 (78%)
	f) in the case of Māori, information documenting whether the victim and their family were offered a Māori advocate?	12 (44%)	19 (70%)
7.2	Does the DHB have sexual abuse specific forms that include:		
	a) a genital diagram?	24 (89%)	24 (89%)
	b) a consent form?	23 (85%)	23 (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%)	27 (100%)
	a) CYF notification?	27 (100%)	27 (100%)
	b) Police notification?	17 (63%)	19 (70%)
7.4	Are staff provided training on documentation for children regarding abuse and neglect?	27 (100%)	27 (100%)

	"YES" responses	84 mo FU n (%)	96 mo FU n (%)
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%)	26 (96%)
	b) Is the evaluation process standardised?	22 (82%)	25 (93%)
	c) Do evaluation activities measure outcomes, either for entire programme or components thereof?	26 (96%)	26 (96%)
	d) Does the evaluation of the programme include relevant review/audit of the following activities:		
	Identification, risk assessment, admissions and referral activities?	18 (67%)	24 (89%)
	Monitoring trends re demographics, risk factors, and types of abuse?	14 (52%)	16 (59%)
	Documentation?	20 (74%)	22 (82%)
	Referrals to CYF and the Police?	21 (78%)	23 (85%)
	Case reviews?	23 (85%)	24 (89%)
	Critical incidents?	20 (74%)	21 (78%)
	Mortality morbidity review?	20 (74%)	24 (89%)
	Policy and procedure reviews?	26 (96%)	27 (100%)
	e) Do the evaluation activities include:		
	Multidisciplinary team members?	26 (96%)	27 (100%)
	Police?	22 (82%)	27 (100%)
	CYF?	26 (96%)	27 (100%)
	Community agencies?	20 (74%)	26 (96%)
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%)	24 (89%)
8.3	Do health care providers receive standardized feedback on their performance and on patients from CYF?	18 (67%)	23 (85%)
8.4	Is there any measurement of client satisfaction and community satisfaction with the child abuse and neglect programme?		
	a) client satisfaction?	7 (26%)	11 (41%)
	b) community satisfaction?	17 (63%)	23 (85%)
8.5	Is a quality framework used to evaluate whether services are effective for Māori?	8 (30%)	14 (52%)
8.6	Are data related to child abuse and neglect assessments, identifications, referrals and alert status recorded, collated and reported on to the DHB?	20 (74%)	19 (70%)
8.7	Is the child abuse and neglect programme evident in the DHB quality and risk programme?	16 (59%)	27 (100%)
8.8	Is the responsibility for acting on evaluation recommendations specified in the policies and procedures?	17 (63%)	11 (41%)

	"YES" responses	84 mo FU n (%)	96 mo FU n (%)
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%)	0 (0%)
	b) 10-20 posters or images	2 (7%)	1 (4%)
	c) >20 posters or images	25 (93%)	26 (96%)
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	2 (7%)	0 (0%)
	b) 10-20 locations	2 (7%)	1 (4%)
	c) >20 locations	23 (85%)	26 (96%)
9.3	Are there designated private spaces available for interviewing?		
	c) > 4 locations?	27 (100%)	27 (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?	23 (85%)	24 (89%)
	b) Temporary safe shelter is available?	25 (93%)	27 (100%)