HEALTH RESPONSE TO FAMILY VIOLENCE:

2017 VIOLENCE INTERVENTION PROGRAMME EVALUATION

CENTRE FOR INTERDISCIPLINARY TRAUMA RESEARCH
AUT UNIVERSITY

MINISTRY OF HEALTH
MANATŪ HAUORA

VIP
violence intervention programme

AUT

HEALTH RESPONSE TO FAMILY VIOLENCE:

2017 VIOLENCE INTERVENTION PROGRAMM EVALUATION

Christine McLean
Research Project Manager

Jane Koziol-McLain, PhD, RN
Professor of Nursing

Moira Howson
Research Officer

Acknowledgements

The evaluation team would like to thank all DHB Family Violence Intervention Coordinators, VIP portfolio managers, VIP champions, other DHB managers and staff who facilitate and support the VIP evaluation and audit process. We give our appreciation to members of the VIP national team including Helen Fraser (Ministry of Health Portfolio Manager Violence Prevention Issues Lead), Miranda Ritchie (National VIP Manager for DHBs), and Kara-Dee Morden and Helen Garrick (National Trainers, SHINE). Acknowledgement also to Dr. Nick Garrett, Biostatistician, Department of Biostatistics and Epidemiology, Auckland University of Technology.

This evaluation project was approved by the Multi-region Ethics Committee (AKY/03/09/218, including annual renewal to 5 December 2018). Text from CITR Report No 15 *(Health Response to Family Violence: 2015 Violence Intervention Programme Evaluation)* is included with permission.

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

2018
Centre for Interdisciplinary Trauma Research
Auckland University of Technology
Private Bag 92006
Auckland, New Zealand 1142

CITR Report No 16
ISSN 2422-8532 (Print)
ISSN 2422-8540 (Online)

CONTENT

EXECUTIVE SUMMARY

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

This report documents three VIP evaluation work streams: (1) DHB programme inputs (system infrastructure indicators); (2) DHB outputs (Snapshot clinical audits of service delivery); and (3) DHB improvements (based on Model for Improvement Plan-Do-Study-Act cycles). In this report we focus on DHB data for the two periods 1 July 2015 to 30 June 2016, and 1 July 2016 to 30 June 2017. During this period, DHBs implemented the updated *Family Violence Assessment and Intervention Guideline: Child Abuse and Intimate Partner Violence* (2016).[2]

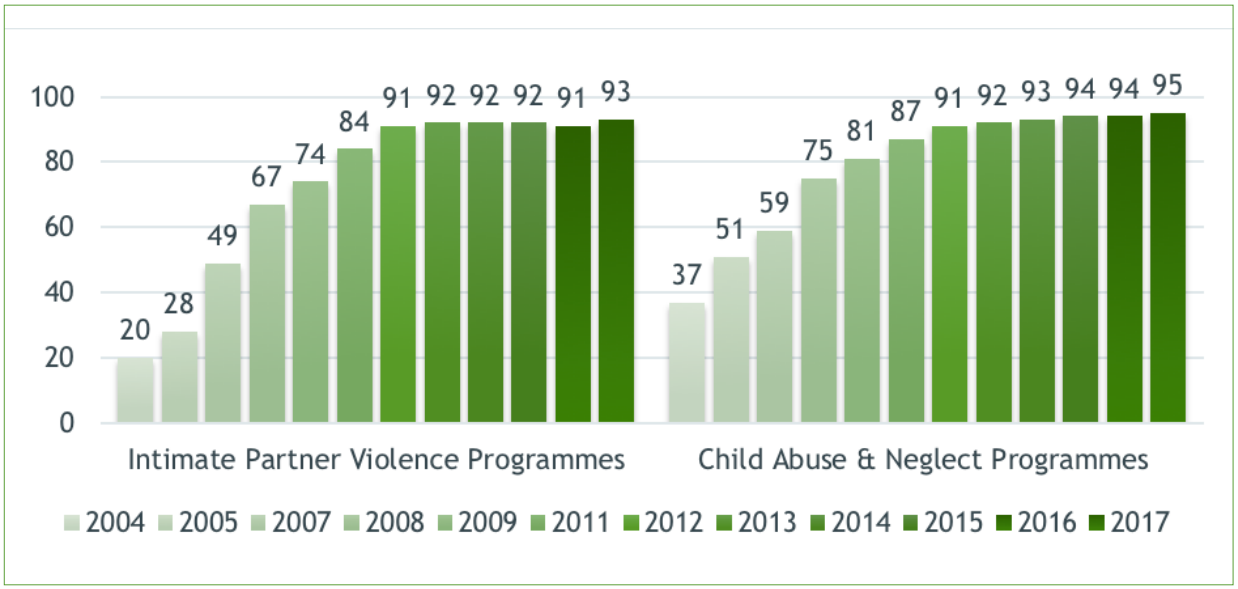
This report provides the Ministry, DHBs and service users with information and accountability data regarding VIP implementation. VIP contributed to government policies relevant during the evaluation period (2016-2017). These included the Cross-Government Family Violence and Sexual Violence Work Programme to reduce family and sexual violence, the NZ Government's Delivering Better Public Services, Supporting Vulnerable Children Result Action Plan,[4] and the Ministry's Statement of Intent 2014 to 2018.[5]

VIP INFRASTRUCTURE AUDITS

Scaling up a quality, sustainable health response to family violence is reliant on quality systems.[6-12] VIP system indicators for intimate partner violence (IPV) and child abuse and neglect (CAN) have been monitored since 2004. The standardised Delphi audit scores measuring system indicators may range from 0 to 100. The Ministry's minimal achievement threshold (target) for 2016 and 2017 was a score ≥ 80.

- After a trend of increasing overall median scores from 2004 to 2012, scores have consistently exceeded 90 over six audit periods (Figure 1).
- The median DHB infrastructure score for IPV programming was 91 in 2016 and 93 in 2017. Ninety-five percent (n=19) of DHBs met the target score ≥80 in 2017.
- The median DHB score for CAN programming was 94 in 2016 and 95 in 2017. One hundred percent (n=20) of DHBs met the target score ≥80 in 2017.

Figure 1. Median Violence Intervention Programme (VIP) scores (2004-2017)



While overall scores are high, there remains variation in programme domain scores. Among the 20 DHBs, in 2017, nine (45%) achieved scores greater than 80 across all IPV and CAN domains. The *Evaluation Activities* domain scores, signalling internal programme monitoring, remain variable. In 2017, 75% (n=15) of DHBs achieved *Evaluation Activities* scores ≥80 for IPV and 65% (n=13) for CAN.

Further system development is also needed to ensure effective response for Māori. In 2017, only 60% (n=12) of DHBs reported evaluating IPV service effectiveness for Māori and 45% (n=9) of DHBs reported evaluating CAN effectiveness for Māori. This is a critical indicator to reduce health inequities.

Inconsistency of VIP training within DHBs and VIP leadership turnover are two concerning system issues. While all 20 DHBs have been approved to deliver the Ministry-approved standardised national VIP training package, the proportion of staff that have been trained varies across professions and services. In many locations, services are unable to report the proportion of staff members that have completed the core VIP training. Turnover of VIP coordinators, managers and service champions remains high, 80% of DHBs had at least one change in their VIP team in 2017. Turnover of programme leaders, with typically extended periods with no incumbent, pose a risk for VIP quality and sustainability.

VIP SNAPSHOT CLINICAL AUDITS

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

Snapshot audits began in 2014. All DHBs are now required to submit Snapshot data addressing IPV service delivery in the following six services: Postnatal Maternity, Child Health inpatients, Sexual Health, Emergency Department, Alcohol & Drug and Community Mental Health Services. All DHBs are also required to submit Snapshot data addressing CAN service delivery to children under 2 years seen in the Emergency Department. DHB Snapshot audits involve annual retrospective reviews of a random selection of 25 clinical records from the three-month period 1 April to 30 June for each of the targeted services.

Snapshot clinical audit benchmarks have been identified:

- System reliability is achieved when a standard action occurs at least 80% of the time.[14] Therefore, the VIP aims to achieve IPV and CAN assessment rates ≥ 80%.
- The quality of IPV screening (routine enquiry) influences women's decisions whether or not to disclose IPV to a health worker.[15,16] With an estimated New Zealand population past year IPV prevalence rate among women of ≈ 5%,[17,18] VIP expects IPV disclosure rates among women seeking health care to be at least 5%.
- Based on the prevalence of CAN indicators (such as the number of National Child Protection Alerts), VIP expects the rate of child protection concern identification to be at least 5%.

CHILD PROTECTION SERVICE DELIVERY

CAN Assessment

- Among children under two years of age who presented to an emergency department during the three-month audit period, 26% were assessed for child abuse and neglect in 2016, increasing to 39% in 2017.
- Nationwide, we estimate that between April and June 2017, over six thousand (6,197) emergency department health assessments of children under two years of age included a child protection assessment.

---

[a] In this report, IPV assessment, IPV screening and routine enquiry are used interchangeably. With the increasing alignment to the 2016 Guideline, language will transition to 'routine enquiry'.

CAN Concern

- Between April and June 2017, among children whose assessment included a review of child protection indicators, we estimate that a concern about their safety was identified in over 600 (10%), all of whom received a specialist consultation.

Table 1. New Zealand estimates of children under two years of age who received child abuse and neglect assessment and service during an emergency department visit (April – June, 2016 and 2017)

	Children assessed for abuse and neglect		CP Concern (≥1 positive indicator)		Specialist Consultation	
	2016	2017	2016	2017	2016	2017
Mean (w) 95% CI	26% 21%, 32%	39% 33% 45%	12% 8%, 15%	10% 7% 13%	93% *	100% *
Estimated number of children	3,404	6,197	394	601	380	601

Notes: The 20 DHBs reported a total 12,864 (2016) and 15,873 (2017) emergency department visits for children under two years of age during the three-month Snapshot audit periods (April – June). The national mean (w) is weighted by the number of children seen in each DHB. Proportion of child protection (CP) concern is among those who received a child abuse and neglect (CAN) assessment. Proportion of specialist consultation is among those with an identified CP concern. Confidence intervals not calculated for specialist consultation due to small numbers within individual DHBs. See definitions and eligibility criteria in Appendix C. Historical data (2014–2015) is available in 'Findings: Snapshot' Chapter.

INTIMATE PARTNER VIOLENCE SERVICE DELIVERY

Assessment

- The proportion of women presenting to sexual health services assessed for IPV increased from 54% in 2016 to 67% in 2017 (See Table 2).
- Approximately two in every three (61%) new female patients aged 16 years and over in community alcohol and drug services and one in three (43%) in community mental health services are assessed for IPV.
- Approximately one in every two (53%) women admitted to postnatal maternity services are assessed for IPV (a similar result to 2016).
- For children admitted to child health inpatient services, approximately four in ten (39%) of their female caregivers are assessed for IPV.
- Approximately one in three women (30%) presenting to emergency department services are assessed for IPV.

Disclosure and Referrals

- The 2017 IPV disclosure rate among women in sexual health services (19%) and adult emergency department (12%) is at least three times higher than the disclosure rate for women in postnatal maternity (4%), and double that for female caregivers in child health (7%).

Table 2. New Zealand estimates of women who received intimate partner violence (IPV) assessment and intervention across DHB services (April – June, 2016 and 2017)

	Women assessed for IPV		Abuse disclosures		Specialist referrals	
Service	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**
Postnatal Maternity Inpatient (20/20 DHBs reporting) (Eligible population 9,521 in 2016 and 11,229 in 2017)						
Mean (w) 95% CI	52% 46%, 58%	53% 49%, 57%	3% 2%, 4%	4% 3%, 6%	83% *	60% *
Estimated number	4,954	5,965	138	264	125	232
Child Health Inpatient (20/20 DHBs reporting) (Eligible population of female caregivers 12,335 in 2016 and 12,988 in 2017)						
Mean (w) 95% CI	42% 36%, 48%	39% 36%, 43%	4% 2%, 5%	7% 5%, 9%	75% *	69% *
Estimated number	5,180	5,118	193	339	125	255
Sexual Health (15/15 DHBs reporting) (Eligible population 7,288 in 2016 and 6,878 in 2017)						
Mean (w) 95% CI	54% 44%, 63%	67% 56%, 79%	15% 11%, 19%	19% 11%, 26%	69% *	78% *
Estimated number	3,917	4,643	589	860	388	627
Emergency Department (20/20 DHBs reporting) (Eligible population 97,067 in 2016 and 101,320 in 2017)						
Mean (w) 95% CI	27% 24%, 29%	30% 26%, 34%	14% 11%, 18%	12% 9%, 15%	94% *	78% *
Estimated number	25,758	30,330	3,658	3,544	3,581	2,418
Alcohol and Drug (12/16 DHBs reporting) (Eligible population of new women clients 1,581 in 2016 and 1,454 in 2017)						
Mean (w) 95% CI	52% 38%, 67%	61% 47%, 76%	34% 25%, 44%	27% 19%, 35%	59% *	88% *
Estimated number	829	894	285	239	152	175
Community Mental Health (18/20 DHBs reporting) (Eligible population of new women clients 3,373 in 2016 and 5,664 in 2017)						
Mean (w) 95% CI	52% 43%, 62%	40% 32%, 48%	24% 19%, 29%	28% 22%, 34%	64% *	90% *
Estimated number	1,769	2,369	422	689	257	597

Notes: The national mean is weighted by the number of women seen in each DHB. The proportion of IPV disclosures is among those who were assessed for IPV; proportion of IPV referrals is among those who disclosed IPV; confidence intervals not calculated for referrals due to small numbers within individual DHBs. See definitions and eligibility criteria in Appendix C. Historical data (2014–2015) is available in 'Findings: Snapshot' Chapter.

National estimates indicate that most women who received specialist family violence services in 2017 and 2016 during the three-month audit period were referred through the emergency department, community mental health or sexual health services (Table 2). These services have IPV disclosure rates greater than 5%; and, in the case of emergency department service, high patient volumes (Table 2 and Figure 2).

Average assessment and disclosure rates mask variability in service delivery. In 2017, there were 11 service locations that achieved IPV assessment rates ≥ 80% and disclosures rates ≥ 5% (within the target zone). These were located in 7 DHBs. This was an increase from seven service locations in 2016. The 2017 rate of achieving the benchmark was 10%, based on 112 VIP service locations assessed in the Snapshot audit (20 DHBs X 6 services less 8 contracted out services).

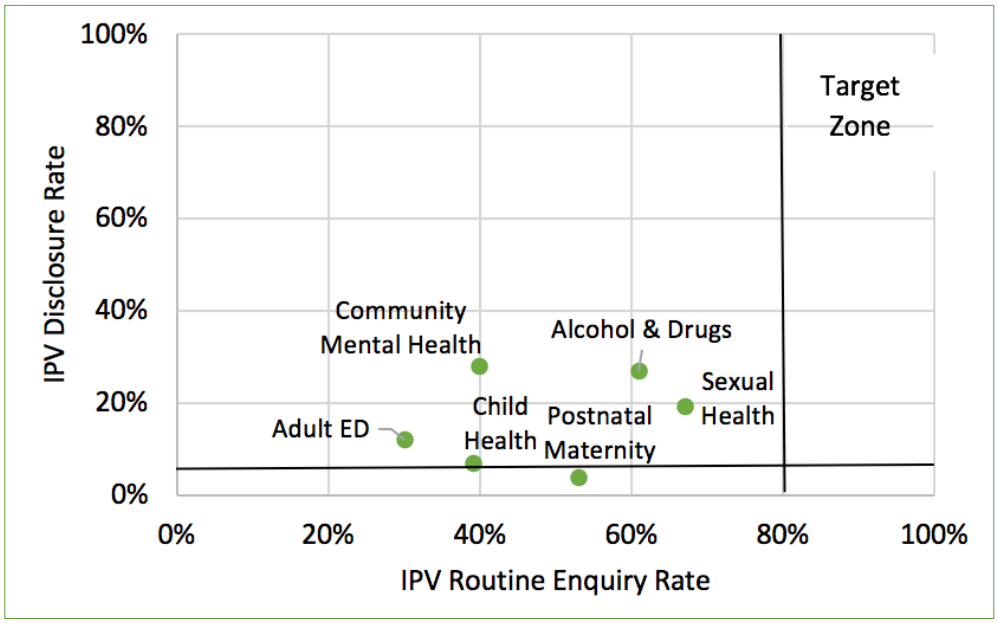


Figure 2. Intimate partner violence Snapshot assessment and disclosure rates: 2017 national average (April–June)

VIP IMPLEMENTATION

Across Ministry of Health targeted services, in 2017, VIP services were being delivered in:

- 20 (100%) DHB Child Health inpatient services
- 20 (100%) DHB Postnatal Maternity inpatient services
- 19 (95%) DHB Adult Emergency Departments
- 15 (75%) DHB Sexual Health community services
    - 2 (10%) DHBs have amalgamated their sexual health community services under a regional service
    - 3 (15%) DHBs fund NGOs to provide sexual health community services

- 18 (90%) DHB Community Mental Health services
    - 2 (10%) DHBs have not implemented VIP in Community Mental Health Services
- 15 (75%) DHB Community Alcohol and Drug Services
    - 2 (10%) DHBs have amalgamated their Community Alcohol & Drug services under a regional service
    - 1 (5%) DHB funds an NGO to provide alcohol and drug services
    - 2 (10%) DHBs have not implemented VIP in Community Alcohol and Drug services

QUALITY IMPROVEMENT INITIATIVES: MODEL FOR IMPROVEMENT PLAN-DO-STUDY-ACT (PDSA)

The Model for Improvement PDSA process[19] provides a mechanism to improve the consistency and quality of family violence service delivery. There were several DHBs in 2016 and 2017 that documented performance improvements based on testing a change action. However, many PDSA objectives continue to be too complex and beyond the scope of a PDSA cycle.

VIP DELPHI TOOL REVIEW

Fifty family violence experts participated in a Delphi process beginning in 2017 to revise the current Delphi infrastructure tools. They included FVIP coordinators, clinicians, researchers, Māori health and family violence specialists from across New Zealand. The new tool is shorter, combining the IPV and CAN audits into one tool with 9 domains and 58 items. New domains include organisational leadership, cultural responsiveness and resource funding. The revised tool is ready to be piloted by DHBs in future audits.

SUMMARY

VIP 2016 and 2017 evaluation data indicate that while VIP is being successfully implemented in a small number of service locations in selected DHBS, further improvements are needed to deliver a consistent, quality service nationwide to vulnerable children, women and whānau or families living with violence. A focus on consistent and quality VIP service delivery is required from Ministry of Health, District Health Boards and target services in order to meet the challenge to reduce New Zealand's high child abuse and neglect and intimate partner violence rates. Senior clinical leadership and quality improvement initiatives will continue to be a focus for the VIP programme in the near future.

INTRODUCTION

Internationally and within New Zealand, family violence is acknowledged as a preventable public health problem and human rights violation that impacts significantly on women, children, whānau and communities.[10,20-23] Early identification of people subjected to violence followed by a supportive and effective response can improve safety and wellbeing.[10] The health care system is an important point of entry for the multi-sectoral response to family violence, including both preventing violence and treating its consequences.

The Ministry of Health ('the Ministry') began the Family Violence Health Intervention Project in 2001 (see Appendix A) and launched the renamed Violence Intervention Programme (VIP) in 2007. VIP seeks to reduce and prevent the health impacts of violence and abuse through early identification, assessment and referral of victims presenting to health services. This programme provides the infrastructure for the health sector response, which is one component of the multi-agency approach to reduce family violence in New Zealand led by the Ministerial Group on Family Violence and Sexual Violence.[3] The Violence Intervention Programme has been strategically aligned with the NZ Government's Delivering Better Public Services, Supporting Vulnerable Children Result Action Plan,[4] and the relevant policies during the evaluation period (2016-2017). These included the Government's Delivering Ministry's Statement of Intent 2014 to 2018.[5] The Better Public Services Target 2017 Result 4: Vulnerable Children aims to "reduce the number of children experiencing physical and sexual abuse by 20% by 2021"[4]. This target is based on the Ministry for Children, Oranga Tamariki data on substantiated physical and sexual abuse. In addition to the target measure, Oranga Tamariki will also be tracking two supporting measures: the total number of children experiencing abuse of any type including physical, sexual, emotional abuse and neglect; and, the percent of children who experience a repeat Report of Concern within 12 months. The Ministry of Health's VIP programme is ideally placed to provide active support and cooperation to deliver services and support the work of Oranga Tamariki to reduce the number of children experiencing physical and sexual abuse.

VIP in DHBs is premised on a standardised, comprehensive systems approach[10-12,24] supported by six programme components funded by the Ministry (Figure 3). These components include:

- District Health Board Family Violence Intervention Coordinators (FVIC).
- Ministry of Health Family Violence Assessment and Intervention Guideline: Child Abuse and Intimate Partner Violence (2002, 2016)
- Resources that include a Ministry Family Violence website, a VIP section on the Health and Innovation Resource Centre (HIIRC) website, posters, cue cards, pamphlets, policy and procedure templates and the VIP Quality Improvement Toolkit.
- Technical advice and support provided by a National VIP Manager for DHBs, National VIP Training and national and regional Family Violence Intervention Coordinator network meetings.
- National training contracts for DHB staff, midwives and primary care providers.
- Monitoring and evaluation of DHB family violence responsiveness.

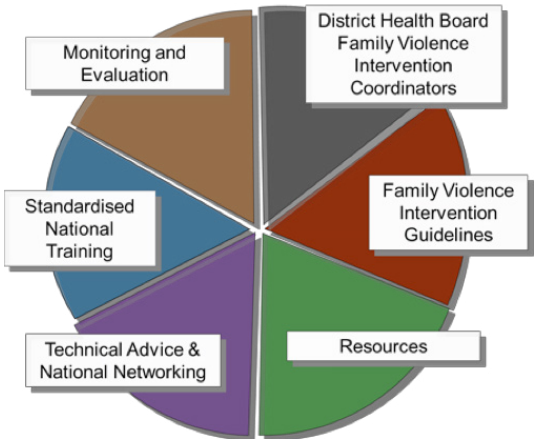


Figure 3. Ministry of Health VIP Systems Support Model (DHBs)

This report documents the results of three evaluation work streams. **Firstly,** DHB programme inputs (system infrastructure) are assessed at the DHB level against criteria for an ideal programme using Delphi tools.[25-27] The quantitative Delphi scores provide a means of monitoring infrastructure across the 20 New Zealand DHBs over time. This work stream has led to important national initiatives directing programme funding, development of the VIP Quality Improvement Toolkit, Model for Improvement workshops and a Whānau-Centred resource.[28] **Secondly,** programme service delivery is measured by VIP Snapshot clinical audits. Snapshot audits conducted in New South Wales have proved useful in monitoring service delivery.[29] Snapshot clinical audits measure women and children assessed for violence and abuse and women and children with a violence concern who receive specialist assistance. The Snapshots provide accountability data and the inaugural audits in 2014 serve as baseline for monitoring the effect of system changes. **Thirdly,** Model for Improvement Plan-Do-Study-Act (PDSAs)[19] worksheets are part of the evaluation process as a quality improvement initiative. DHBs complete two PDSAs focused on improving DHB IPV routine enquiry and disclosure rates or CAN child protection assessment and concern rates.

This evaluation report provides practice-based evidence of the VIP inputs, outputs and outcomes (Figure 4). Together, the Delphi infrastructure, programme information and Snapshot audits deliver data to the Ministry of Health, the VIP National Management Team and other key government departments involved in strategies, resourcing and developments, to reduce the rate of child abuse and neglect and intimate partner violence experienced within New Zealand families and whānau. It also contributes to the whole of government priorities on protecting vulnerable children[30] and Whānau Ora.[31]

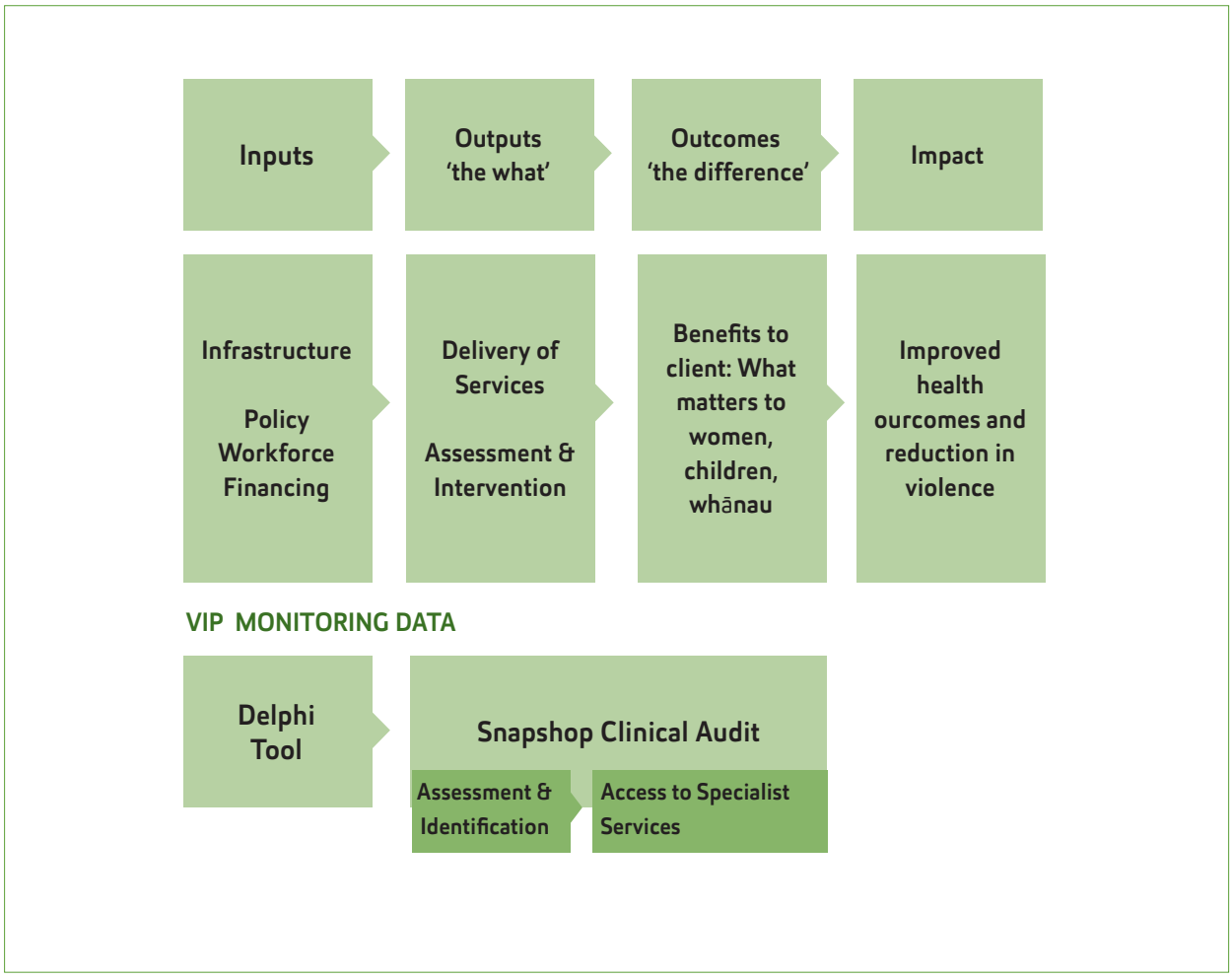


Figure 4. VIP Evaluation Monitoring Data Sources

In this report we present the VIP evaluation data for 2016 and 2017, including historical data for analysis of trends over time. Evaluation data (a) measures programme infrastructure indicators; (b) measures service delivery consistency and quality in Ministry of Health targeted services and (c) fosters system improvements.

METHODS

Ministry of Health VIP contracts with DHBs specified participation in the evaluation process. All 20 New Zealand DHBs participated (see Appendix B). The evaluation project was approved by the Multi-region Ethics Committee (AKY/03/09/218 with annual renewal up to 4/12/18).

Evaluation procedures are based on a philosophy of supporting programme leaders in building a culture of improvement.[19,32] Details of the evaluation processes are outlined in Figure 5 and Appendix C and D.

The 2016 audit process began on 22 August 2016 with a letter from the Ministry advising DHBs of the upcoming audit round and the 2017 audit process on 21 August 2017. Following the Ministry's letters to DHBs, the evaluation team distributed audit documentation with instructions and evaluation resources. Evaluation data was due from DHBs in October of 2016 and 2017.

DHBs completed their evaluation data (submitting Delphi tool files, completing online Snapshot clinical audits and submitting PDSA worksheets) between October 2017 and January 2018. Following review of all DHB evaluation data, the evaluation team provided a report to the DHB CEO, copied to the DHB VIP portfolio manager, and the Ministry.

In 2017, in addition to self-audit, external site visits were conducted at three DHBs. Two DHBs were randomly selected and the third selected due to significant staff turnover. During the visit, Delphi, Snapshot and PDSAs findings were discussed. The objectives of the site visits were to (a) support a culture of improvement within DHB Violence Intervention Programmes, (b) learn about programme context and challenges and (c) monitor self audit data accuracy.

DELPHI SYSTEM INFRASTRUCTURE AUDIT

DHBs were invited to submit self audit data in October 2016 (for the one-year period 1 July 2015 to 30 June 2016) and in October 2017 (for the one-year period 1 July 2016 to 30 June 2017). Requested documentation included:

1. Intimate Partner Violence Audit Tool
2. Child Abuse and Neglect Audit Tool

IPV & CAN PROGRAMME EVALUATION AUDIT TOOLS

Quantitative self audit data were collected applying the *Intimate Partner Violence (IPV) Programme Evaluation Tool* and *Child Abuse and Neglect (CAN) Programme Evaluation Tool*. (Please note that the IPV Tool was previously referred to as the Partner Abuse (PA) Tool). These tools reflect modifications of the *Delphi Instrument for Hospital-Based Domestic Violence Programme*[27,33,34] for the Aotearoa New Zealand context. The audit tools assess programmes against criteria for an ideal programme.

The *Partner Abuse (PA)* Tool has been used without change across all audit periods. In 2007, a Delphi process with a New Zealand expert panel was conducted to revise the *Child Abuse and Neglect (CAN)* Tool to improve its content validity.[25] This *Revised CAN Tool* has been used since the 48 month follow-up audit.[35] The audit tools are available (open access at www.aut.ac.nz/vipevaluation) as interactive Excel files, allowing users to see measurement notes, enter their indicator data and instantly receive their scores to feed into improvement planning.

Figure 5. 2016 and 2017 VIP Evaluation Plan (PDSA = Plan, Do, Study, Act)

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

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

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

Figure 6. Audit Tool Domains

ANALYSIS

Self audit data were exported from Excel audit tools into a SPSS Statistics (Version 24) file. Score calculations were confirmed between Excel and SPSS files. In this report we present overall Delphi and domain scores covering audits from 2004 to 2017. Box plots and league tables are used to examine the distribution of scores over time (see Appendix F: *How to Interpret Box Plots*). The unit of analysis for the infrastructure (Delphi Tool) analysis was hospital until 2011. From 2012 onwards, the unit of analysis has been District Health Board (DHB). The change to analysis by DHB was implemented due to a lack of hospital infrastructure variation within DHBs with more than one hospital, and recognising that programme management (and reporting to the Ministry) occurs by DHB. As individual extreme scores influence mean scores, we favour reporting medians (and box plots).

PROGRAMME INFORMATION

VIP programme information was collected as part of the DHB self audit process in 2016 (Appendix D). Programme information data collection overlapped with information reported in bi-annual reports to the Ministry so was suspended in 2017 to reduce reporting burden.

SNAPSHOT CLINICAL AUDIT

The Snapshot clinical audits aim to collect "accountability data that matter to external parties"[13] and use a nationally standardised reporting process to monitor service delivery and inform performance improvements.[36]

Snapshot audits provide estimates of: (a) VIP outputs – women and children assessed for violence and abuse, and (b) VIP outcomes – women and children with a violence concern who received specialist assistance. The inaugural VIP Snapshots occurred in 2014 and included two designated services, with a further two services added for the 2015 and 2016 evaluations respectively.

Data on training is also included. Training is a necessary, though insufficient, pre-requisite to support a sensitive, quality response to family violence. DHBs were asked to report the proportion of staff (e.g. doctors, nurses, midwives, social workers) in designated services who have received the national VIP training.

BENCHMARKING

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

- System reliability is achieved when a standard action occurs at least 80% of the time.[14] Therefore, the VIP aims to achieve IPV and CAN assessment rates ≥ 80%.
- The quality of IPV routine enquiry (screening) influences women's decision whether or not to disclose IPV to a health worker.[15,16] The estimated New Zealand population past year IPV prevalence rate among women is ≈ 5%.[17,18] The prevalence of IPV reported by women receiving health care services is higher than the population prevalence in both international and New Zealand research.[37-41] This is not surprising given the negative impact of IPV on health.[42] The VIP expects IPV disclosure rates among women seeking health care to be ≥ 5%.
- Based on the prevalence of CAN indicators (such as CAN alerts), VIP expects the rate of child protection concern identification to be ≥ 5%.

SELECTED SERVICES

Seven services were audited for the 2017 and 2016 VIP Snapshot audits.

Intimate Partner Violence Clinical Audit:

- **Postnatal Maternity** inpatient
- **Child Health** inpatient (female guardians, parents or care givers assessed for partner abuse)
- **Sexual Health**
- **Emergency Department** [adult]
- **Community Alcohol and Drug Services**
- **Adult General Community Mental Health Services**

Child Abuse & Neglect Clinical Audit:

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

SAMPLING AND ELIGIBILITY

Within each DHB, for each selected service, a random sample of 25 eligible records during the three-month audit period (**1 April – 30 June**) were retrospectively reviewed by DHB VIP staff or delegates for both 2016 and 2017. Therefore, the Snapshot involved each DHB reviewing a total of 175 clinical records each year.

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

Eligibility criteria were (see also Appendix C for service definitions and record review instructions):

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

DATA ELEMENTS

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

- DHB, site, and service
- Total number of eligible patients (women, or child – depending on service) in the designated service during the three-month audit period 1 April 2016 to 30 June 2016.
- Ethnicity – up to three ethnicities per patient were able to be recorded, consistent with Ministry of Health standard[43]
- Child's age (ranging between 0 – 16 years) for child health inpatient service only.
- Adult's age and triage status for emergency department only
- Intimate Partner Violence (IPV) variables:
    - IPV screen (yes or no)
    - IPV disclosure (yes or no)
    - IPV referral (active (onsite), passive (offsite) or none).
- Child Abuse and Neglect (CAN) variables:
    - Child protection risk assessment (yes or no)
    - Child protection concern identified (yes or no)
    - Child protection consultation (yes or no).

ANALYSIS

Snapshot data were exported from the secure web-based server in an Excel file and imported into SPSS Statistics (Version 24). Descriptive analysis was conducted for each data element (see prior section). For reporting ethnicity, data was prioritised for Māori (Māori and non-Māori).

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

The electronic VIP Snapshot reporting system provides service results and a graph on completion of the input for each service. An overview of VIP Snapshot data was presented to the meetings of the National Network of the Violence Intervention Programme in November of 2016 and 2017.

QUALITY IMPROVEMENT – PLAN-DO-STUDY-ACT CYCLES

The Model for Improvement Plan-Do-Study-Act (PDSA) cycle was introduced into the quality and evaluation activities of the VIP Programme in 2015 and will continue to be part of the AUT Programme Evaluation process until 2018.

The Model for Improvement[19] is a simple framework to guide specific improvements in personal work, teams or natural work groups. The model comprises three basic questions: "What are we trying to accomplish?"; "How will we know that a change is an improvement?"; and "What change can we make that will result in an improvement?". The fourth

element of the model uses the Plan–Do–Study–Act cycle for testing the change or innovation on a small scale to see if it will result in an improvement. An essential component of developing a PDSA is the making of a prediction about what will happen during the PDSA cycle. Prediction combined with the learning cycle reveals gaps in knowledge and provides a starting place for growth. Without it learning is accidental at best, but with it, efforts can be directed toward building a more complete picture of how things work in the system.

Two PDSA plans were requested to be submitted for approval by the AUT Evaluation Team prior to implementation (i.e. writing up the PLAN phase before undertaking the DO, STUDY, and ACT phases of the PDSA cycle). They were directed to be aimed at improving service delivery using their 2016 and 2017 Snapshot results. PDSA cycles were to improve rates of family violence assessment or specialised consultation, or cultural responsiveness for Māori. A PDSA pack (including a template, resource and instructions) was distributed and ongoing support, coaching and feedback was provided by the Evaluation Team. DHBs were to submit two PDSA plans to evaluators by November in 2016 and 2017. Completed PDSA worksheets were to be submitted by April of the following year.

FINDINGS: SYSTEM INFRASTRUCTURE (DELPHI)

INTIMATE PARTNER VIOLENCE PROGRAMME

Following a trend of increasing median intimate partner violence programme scores from 2004 to 2012, scores have now been consistently > 90 over six audit periods (Figure 7 and Appendix I).

- The 2016 and 2017 median intimate partner violence programme scores were 91 and 93 respectively.
- Intimate partner violence programme scores > 80 were achieved by 95% (n=19) of DHBs.

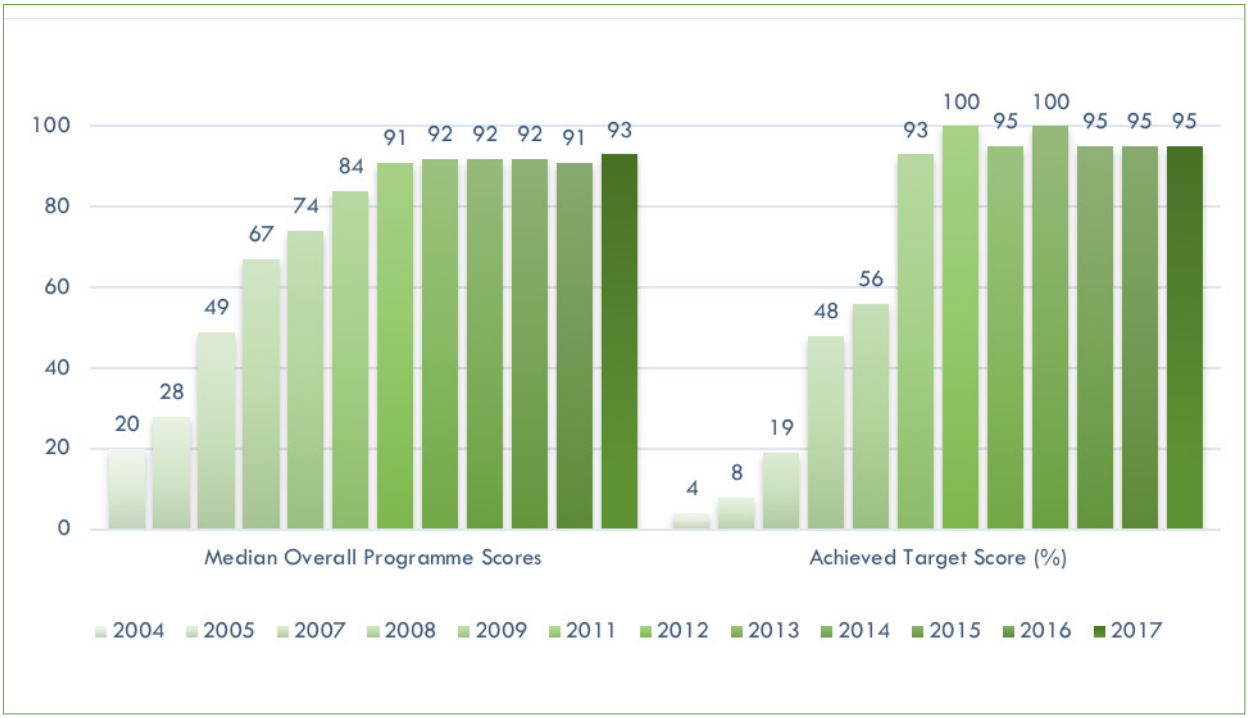


Figure 7. Median intimate partner violence programme scores 2004–2017

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

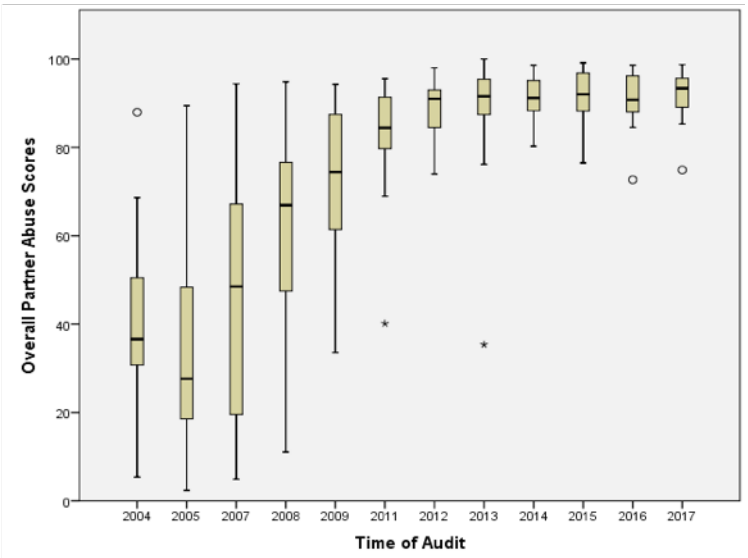


Figure 8. Overall intimate partner violence score distribution over time.

Variability in scores over time is shown in Figure 8. Since the 2011 audit, scores have been consistently at the higher range of the scale. In 2017 the intimate partner violence score ranged from 75 to 99 (73 to 99 in 2016). The 2017 standard deviation was 5.52 (6.23 in 2016)

INTIMATE PARTNER VIOLENCE PROGRAMME DOMAINS

- All nine intimate partner violence programme domain median scores exceeded the target score of 80 (Table 3).
- Sixty percent (n=12) of DHBs achieved the target score (≥80) across all nine domains.
- Twenty-five percent (n=5) of DHBs scored less than 80 in the *Evaluation Activities* domain.

Table 3. 2017 and 2016 intimate partner violence domain results (N=20 DHBs)

Domain	Median Scores		Minimum and Maximum scores		No. DHBs below target (< 80)	
	2017	2016	2017	2016	2017	2016
Policies & Procedures	90	91	74–100	74–98	1	1
Physical Environment	100	98	58–100	37–100	4	1
Cultural Environment	98	94	35–100	72–100	2	2
Training of Providers	100	100	78–100	49–100	2	3
Screening & Safety Assessment	88	88	80–100	74–100	0	1
Documentation	90	90	71–100	67–100	1	4
Intervention Services	100	97	83–100	67–100	0	2
Evaluation Activities	92	92	51–100	51–100	5	5
Collaboration	100	100	83–100	84–100	0	0

Frequencies for individual intimate partner violence programme tool indicators are provided in Appendix I. Thirteen indicators where not achieved in 2017 by four or more DHBs (<80%). For example: full-time FVIC (60%), assessment of client or community satisfaction with the programme (70%), evaluation of the programme for Māori (60%), and inclusion in the programme steering/governance group of a member of medical staff (75%) and representing security (60%).

INTIMATE PARTNER VIOLENCE PROGRAMME LEAGUE TABLES

The DHB league table for the 2017 and 2016 intimate partner violence intervention programme score is presented in Table 4. The amount of change since the last audit (absolute score difference) ranged from a decrease of 14 to an increase of 14.

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

Table 4. DHB intimate partner violence programme scores: League Table (2016 – 2017)

Rank	DHB	2017	2016	Change from 2016
1	Northland	99	99	0
2	MidCentral	98	98	0
3	Counties Manukau	97	97	0
4	Waitemata	96	85	11
5	West Coast	96	96	0
6	Waikato	95	98	-3
7	Whanganui	95	95	0
8	Canterbury	95	97	-2
9	Taranaki	94	91	-3
10	Capital & Coast	94	95	-1
11	Bay of Plenty	93	90	3
12	Southern	92	94	-2
13	Tairawhiti	91	85	6
14	Hutt Valley	90	91	-1
15	Lakes	89	91	-2
16	Hawkes Bay	89	87	2
17	South Canterbury	88	91	-3
18	Wairarapa	87	73	14
19	Auckland	85	86	-1
20	Nelson Marlborough	75	89	-14
	DHB Median	**93**	**91**	**2**

CHILD ABUSE AND NEGLECT PROGRAMME

The overall child abuse and neglect programme median infrastructure scores have been consistently high over six audit periods (Figure 9 and Appendix J).

- The 2017 median child abuse and neglect score was 95.
- Child abuse and neglect programme scores > 80 were achieved by 100% (n=20) of DHBs.

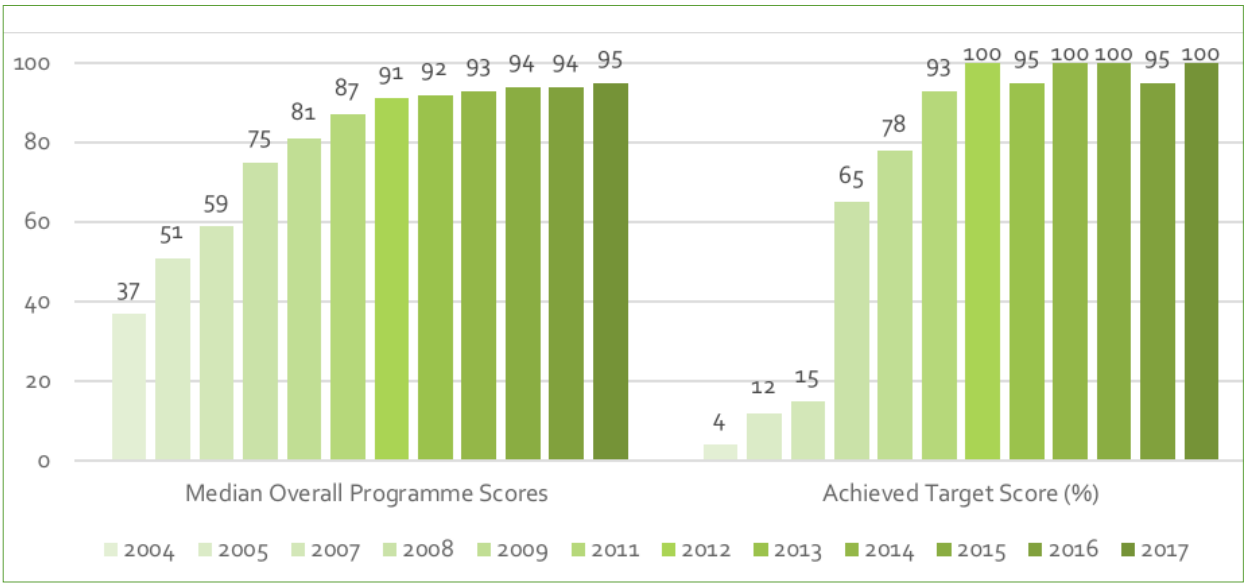


Figure 9. Child abuse and neglect programme scores (2004–2017)

Accompanying higher scores over time, is less score variation (Figure 10). The 2017 child abuse and neglect score ranged from 84 to 99 (77 to 100 in 2016). The 2017 standard deviation was 4.25 (6.19 in 2016).

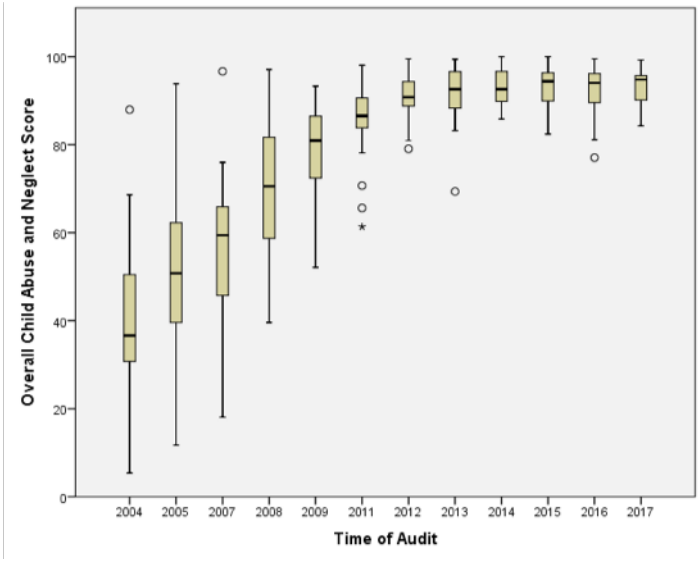


Figure 10. Overall child abuse and neglect score distribution over time

CHILD ABUSE & NEGLECT PROGRAMME DOMAINS

- All nine child abuse and neglect programme domain median scores exceeded the target score of 80 (Table 5).
- Sixty percent (n=12) of New Zealand DHBs achieved the target score (≥80) across all nine domains in 2017, and 55% (n=11) achieved the score in 2016
- Thirty five percent (n=7) of DHBs scored less than 80 in the Evaluation Activities domain in 2017 as did 40% (n=8) in 2016.
- Forty five percent (n=9) of DHBs achieved scores greater than 80 across all partner abuse and child abuse and neglect domains. In 2016 this was achieved by 55% (n=11) of DHBs.

Table 5. 2017 and 2016 child abuse and neglect domain results (N=20 DHBs)

Domain	Median Scores		Minimum – Maximum scores		No. DHBs below target (< 80)	
	2017	2016	2017	2016	2017	2016
Policies & Procedures	95	93	80–100	78–100	0	1
Safety and Security	99	99	88–100	86–100	0	0
Collaboration	100	100	91–100	89–100	0	0
Institutional Culture	96	96	53–100	73–100	2	1
Training of Providers	98	98	71–100	56–100	2	1
Intervention Services	94	93	86–100	80–100	0	0
Documentation	100	95	73–100	70–100	1	2
Evaluation Activities	82	82	15–100	14–100	7	8
Physical Environment	100	100	76–100	68–100	3	3

Frequencies for individual child abuse and neglect programme tool indicators are provided in Appendix K. Fourteen indicators where not achieved in 2017 by four or more DHBs (<80%). For example: VIP training is a KPI for staff (75%), community satisfaction with the CAN programme is assessed (70%), a quality framework is used to assess programme effectiveness for Māori (45%).

CHILD ABUSE AND NEGLECT PROGRAMME LEAGUE TABLES

The DHB league table for the 2016 and 2017 child abuse and neglect intervention programme scores is presented in Table 6. The amount of change since the last audit (absolute score difference) ranged from a decrease of one to an increase of 14.

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

Table 6. DHB child abuse and neglect programme scores: League Table (2016–2017)

Rank	DHB	2017	2016	Change from 2016
1	Counties Manukau	99	100	-1
2	Northland	99	99	0
3	Canterbury	98	98	0
4	MidCentral	96	96	0
5	Lakes	96	93	3
6	Waikato	95	96	-1
7	Capital & Coast	95	94	1
8	Bay of Plenty	95	94	1
9	South Canterbury	95	96	-1
10	Southern	95	95	0
11	West Coast	95	95	0
12	Taranaki	95	91	4
13	Whanganui	94	94	0
14	Auckland	93	98	-5
15	Wairarapa	91	77	14
16	Nelson Marlborough	90	91	-1
17	Hutt Valley	89	89	0
18	Waitemata	87	81	6
19	Tairawhiti	86	84	2
20	Hawkes Bay	84	84	0
	DHB Median	**95**	**94**	**1**

CULTURAL RESPONSIVENESS

VIP recognises culturally responsive health systems contribute to reducing health inequalities. Figure 11 displays the overall score for the sub-set of audit tool indicators (30 indicators for intimate partner violence and 28 for child abuse and neglect) evaluating cultural responsiveness within VIP programmes.

The typical (median) overall *Cultural Responsiveness* scores have been maintained around 90 (±5) for seven audit periods (Figure 11).

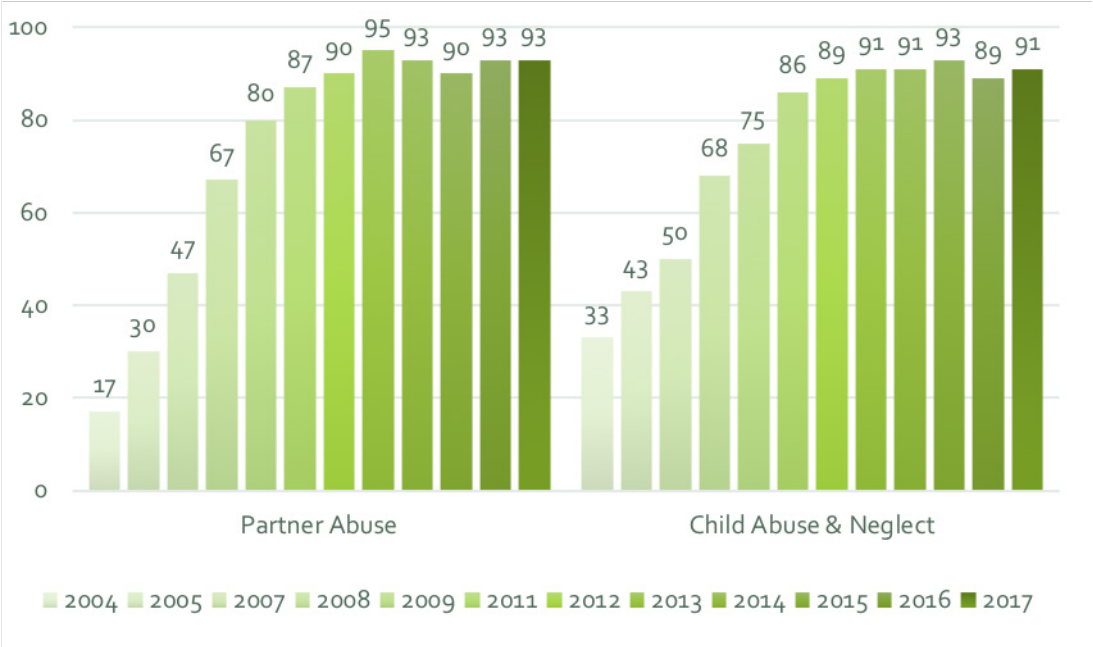


Figure 11. Median VIP Cultural Responsiveness scores 2004–2017

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

90% (n=18) of DHBs collaborate with Māori community organisations and providers to deliver preventive outreach and public education activities.

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

- 60% (n=12) of DHBs, (a reduction from 70% (n=14) in 2016), use a quality framework to evaluate whether intimate partner violence services are effective for Māori.
- 45% (n=9) of DHBs use a quality framework to evaluate whether child abuse and neglect services are effective for Māori (no change from 2016).
- 55% (n=11) of DHBs set aside funding specifically for Māori initiatives associated with intimate partner violence and 60% (n=12) of DHBs set aside funding specifically for Māori initiatives associated with child abuse and neglect.
- 55% (n=11) of DHBs include a non-Māori non-Pakeha representative in the training team for child abuse and neglect (an increase from 10 in 2016).

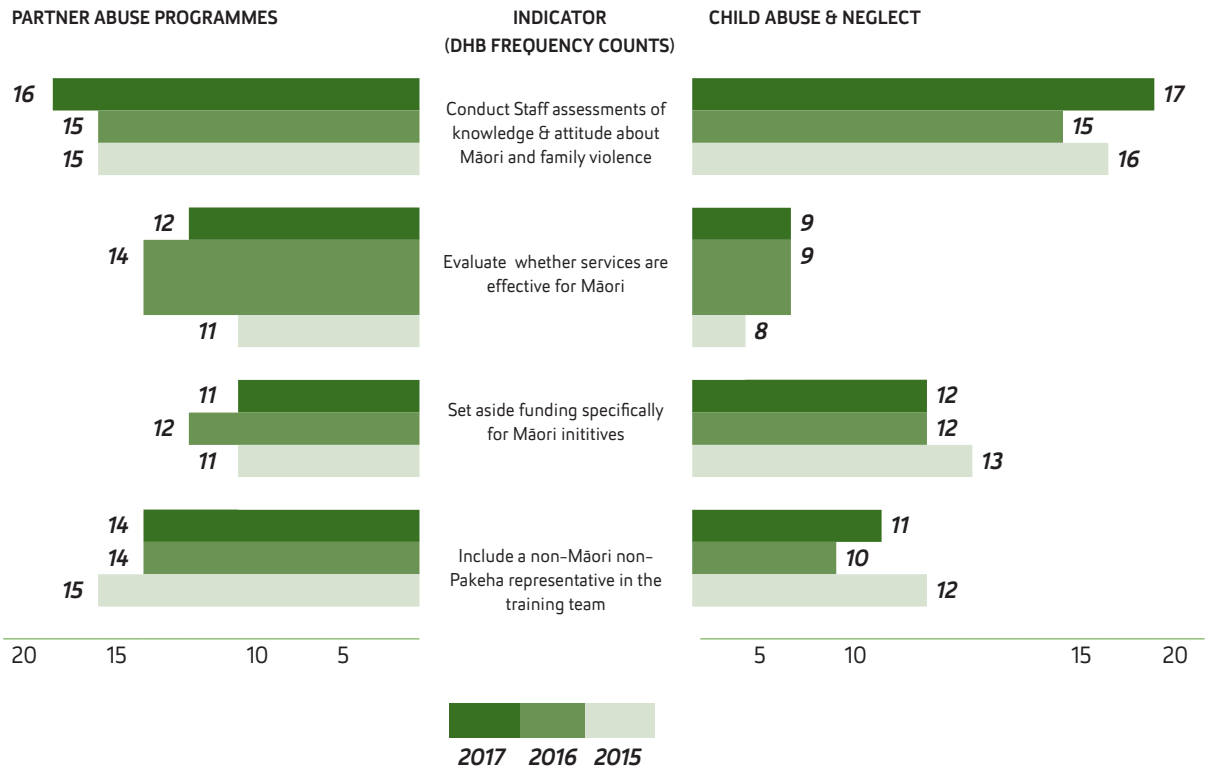


Figure 12. Selected Cultural Responsiveness indicators (n=20 DHBs)

INDEPENDENT AUDIT SCORES

In three selected DHBs (two randomly selected and one selected due to programme staff turnover), independent audits were conducted during site visits. These were in addition to the self audits carried out by the three DHBs. External audits including site visits had not been conducted since 2013. In 2017 the overall mean self and independent audit score differences (self audit minus independent audit score) were 5 and 10 for partner abuse and child abuse and neglect respectively. This is greater than the mean self and external audit score differences in 2013 which were 0.3 and -2.4 for partner abuse and child abuse and neglect respectively. In 2017, there were 11 instances of domain score differences greater than ±4 (Table 7). In the self-audits, child abuse and neglect domains tended to be overestimated, particularly in the *Safety and Security, Documentation and Evaluation Activities* domains. Intimate Partner Violence *Physical Environment* domain tended to be underestimated whereas *Evaluation Activities* domain was significantly overestimated. These differences suggest that repeated self audit without a mechanism of oversight introduces error in the accuracy of self audits. Independent audits (involving site visits) facilitate accuracy as well as provide system learning in a positive, supportive process.

Table 7. Differences between domain self and external audit scores (* mean difference <±4)

Programme	Domain	2017 Mean Difference (self minus external audit)	2013 Mean Difference (self minus external audit)
Child Abuse and neglect	Policies & Procedures	7	*
	Safety & Security	14	*
	Institutional Culture	9	*
	Intervention Services	5	*
	Documentation	27	-10.5
	Evaluation Activities	23	-8.5
Intimate Partner Violence	Physical Environment	-11	*
	Training of Providers	7	8.5
	Screening & Safety	5	*
	Intervention Services	6	13
	Evaluation Activities	32	*

REVISED VIP DELPHI TOOL

The system infrastructure findings demonstrate that since 2011, most DHBs have consistently scored in the high 90s This ceiling effect is unlikely to motivate leadership to focus on ongoing programme enhancements, challenging the quality and sustainability of the programme. Therefore, in 2016, alongside release of the revised Ministry of Health Family Violence Assessment and Intervention Guideline (MOHFVAIG), we began a Delphi process to revise the infrastructure tool.

The aim of the Delphi process was to revise the existing programme infrastructure audit tools to align with the revised Ministry of Health Guidelines, ensure an aspirational, parsimonious, simple to use, and valid tool to measure programme input performance and guide programme enhancements.

The revised Delphi combines the IPV and CAN audits into one tool with 9 domains and a total of 58 items. New domains include organisational leadership, cultural responsiveness and resource funding. The new tool reflects the importance placed on these elements of programme infrastructure by the experts in family violence and the health system who participated in the Delphi review.

Pilot testing in three DHBs indicates that most DHBs who have been scoring in the high 90s are likely to score in the 60s or 70s due to the aspirational nature of the tool. New VIP infrastructure elements are expected to be implemented over time. Future audits will use the revised tool (available at www.aut.ac.nz/vipevaluation).

FINDINGS: SNAPSHOT (CLINICAL AUDITS)

INTIMATE PARTNER VIOLENCE ASSESSMENT AND INTERVENTION

National estimates indicate that most women who received specialist family violence services in 2017 during the three-month audit period were referred through the emergency department (n=2,887), community mental health (574) or sexual health (472) services. These services have IPV disclosure rates greater than 5%; in addition, the emergency department has high patient volumes (Table 8).

- Approximately two in every three women (67%) presenting to sexual health services are assessed for intimate partner violence.
- Approximately one in every two (53%) women admitted to postnatal maternity services are assessed for intimate partner violence (a significant increase from 33% in 2014.)
- For children admitted to child health inpatient services, approximately four in every ten (39%) of their female caregivers are assessed for intimate partner violence.
- Approximately one in every three women (30%) presenting to emergency department services are assessed for intimate partner violence.
- The intimate partner violence disclosure rate among women in sexual health services (19%) and the emergency department (12%) is at least three times higher than the disclosure rate for women in postnatal maternity (3%), and double for female caregivers of children in child health (7%).

Table 8. Population estimates of women who received intimate partner violence assessment and specialist intimate partner violence service (April – June, 2014–2017)

	Women assessed				Disclosures				Referrals			
Service	**2014**	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**
Postnatal Maternity Inpatient												
Population estimate	2935	4,637	4954	5965	257	197	138	264	193	197	125	232
Weighted Mean	33%	48%	52%	53%	9%	4%	3%	4%	75%	100%	83%	60%
95% CI	26%, 39%	42%, 55%	46%, 58%	49% 57%	3%, 14%	2%, 6%	2%, 4%	3% 6%	*	*	*	*
Child Health Inpatient												
Population estimate	4869	4513	5180	5118	259	160	193	339	181	160	125	255
Weighted Mean	39%	35%	42%	39%	6%	4%	4%	7%	70%	100%	75%	69%
95% CI	31%, 48%	33%, 38%	36% 48%	36% 43%	4%, 9%	2%, 5%	2%, 5%	5% 9%	*	*	*	*

	Women assessed				Disclosures				Referrals			
Service	**2014**	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**
Sexual Health												
Population estimate	N/A	2703	3917	4643	N/A	537	589	860	N/A	446	388	627
Weighted Mean		48%	54%	67%		20%	15%	19%		83%	69%	55%
95% CI		42%, 55%	44%, 63%	56% 79%		13%, 27%	11%, 19%	11% 26%		*	*	*
Emergency Department												
Population estimate	*N/A*	*21,924*	*25,758*	*30,330*	*N/A*	*1310*	*3568*	*3544*	*N/A*	*982*	*3581*	*2418*
Weighted Mean		*23%*	*27%*	*30%*		*6%*	*14%*	*12%*		*75%*	*94%*	*78%*
95% CI		*20%, 26%*	*24%, 29%*	*26% 34%*		*4%, 8%*	*11%, 18%*	*9% 15%*		*	*	*
Alcohol and Drug – new female clients presenting to service												
Population estimate	N/A	N/A	829	894	N/A	N/A	285	239	N/A	N/A	152	175
Weighted Mean			52%	61%			34%	27%			59%	88%
95% CI			38%, 67%	47% 76%			25%, 44%	19% 35%			*	*
Community Mental Health – new female clients presenting to service												
Population estimate	N/A	N/A	1769	2369	N/A	N/A	422	661	N/A	N/A	257	597
Weighted Mean			52%	40%			24%	28%			64%	90%
95% CI			43%, 62%	32% 48%			19%, 29%	22%, 34%			*	*

Notes: Proportion of IPV disclosures is among those who were assessed for IPV; proportion of IPV referrals is among those who disclosed IPV; confidence intervals not calculated for referrals due to small numbers within individual DHBs. Auditing for sexual health and emergency department was introduced in 2015, and for community mental health and alcohol and drug services in 2016.

As stated earlier in this report, an IPV routine enquiry rate of 80% or greater is indicative of system reliability; and given the population prevalence, a disclosure rate of 5% or greater is expected as an indicator of screening quality. Snapshot average scores in 2016 and 2017 did not meet the benchmark (target zone, see Figure 13) for any of the six services.

Average assessment and disclosure rates mask variability in service delivery. In 2017, there were 11 service locations that achieved IPV assessment rates ≥ 80% and disclosures rates ≥ 5% (within the target zone; see Appendix L). These were located in 7 DHBs. This was an increase from seven service locations in 2016. The 2017 rate of achieving the benchmark was 10% based on 112 VIP service locations assessed in the Snapshot audit (20 DHBs X 6 services less 8 contracted out services).

Service detail is provided in the following sections.

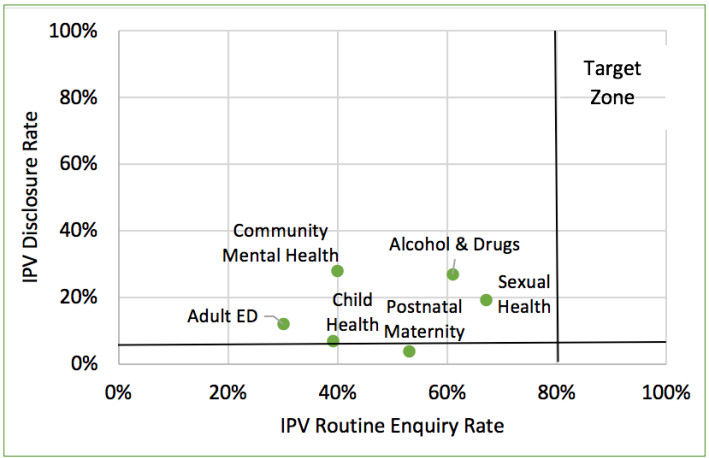
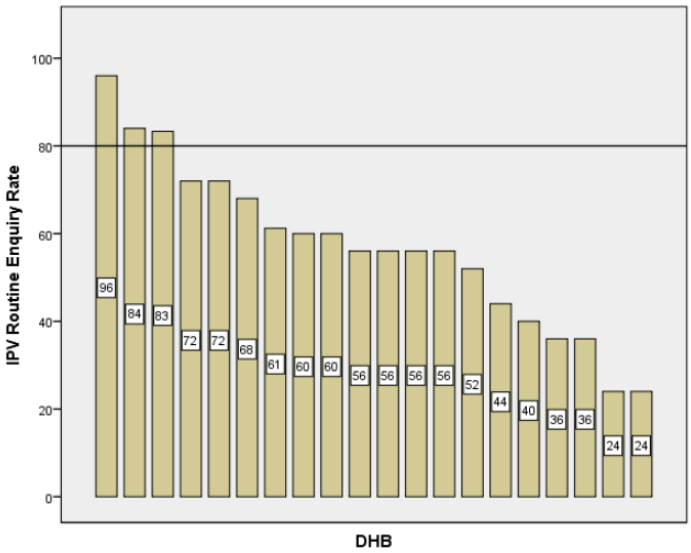


Figure 13. National 2017 average (weighted) intimate partner violence routine enquiry and disclosure rates (April–June)

POSTNATAL MATERNITY

Across the 20 DHBs, 11,229 women were admitted to postnatal maternity services during the three-month Snapshot audit period (1 April – 30 June 2017). Random sampling from the 22 locations (two DHBs reported on two locations) resulted in 548 cases audited for the 2017 Snapshot.



The VIP postnatal maternity snapshot IPV routine enquiry rates ranged from 24% to 96% across DHBs (Figure 14). Three DHBs achieved the target IPV routine enquiry rate of ≥ 80%: Hutt Valley, Taranaki and Bay of Plenty.

Figure 14. DHB postnatal maternity 2017 (April–June) intimate partner violence routine enquiry rates

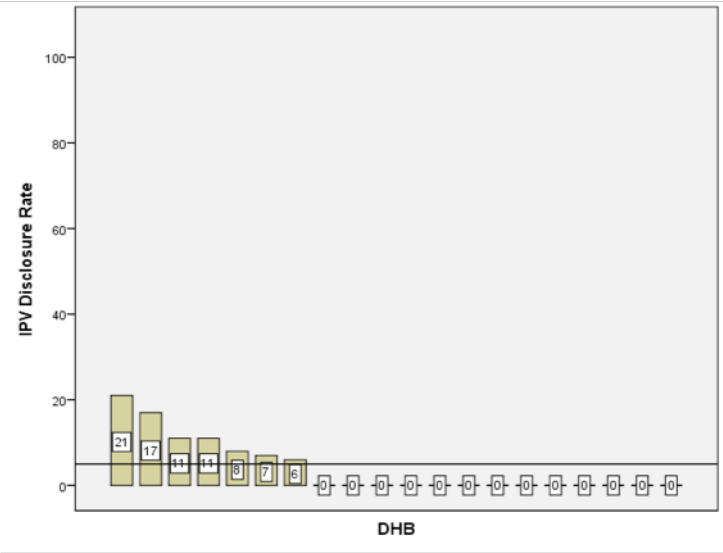


Figure 15. DHB postnatal maternity 2017 (April–June) intimate partner violence disclosure rates

Among women who received an IPV routine enquiry, IPV disclosure rates ranged from 0% to 21% (Figure 15). Seven DHBs met the expectation that at least one of every twenty women who received an IPV routine enquiry would disclose intimate partner violence. The DHBs were: Waikato, Capital & Coast, South Canterbury, Counties Manukau, Northland and Canterbury.

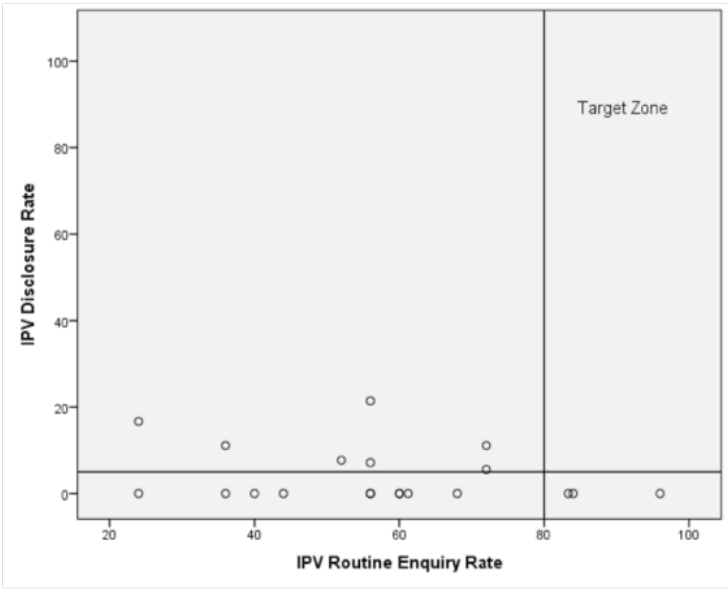


Figure 16. DHB postnatal maternity 2017 (April–June) Intimate Partner Violence routine enquiry and disclosure rates (N=20)

Note: Some points include more than one DHB

In postnatal maternity services, no DHBs achieved the benchmark of ≥ 80% IPV routine enquiry rate with ≥ 5% disclosure rate (Figure 16). Two DHBs (South Canterbury and Canterbury) achieved an IPV routine enquiry rate of 72% with disclosure rates ≥ 5%.

Based on the 2017 Snapshot weighted mean for IPV routine enquiry (53%; 95% CI 49%, 57%), we estimate that 5,965 women admitted to postnatal maternity services during the three-month audit period (April–June 2017) received a VIP intimate partner violence routine enquiry (See Table 9).

Based on the Snapshot weighted mean for IPV disclosure (4%, 95% CI 3%, 6%), we estimate that 264 women disclosed intimate partner violence to a health care provider, with 232 (60%) women receiving a referral for specialist services.

Table 9. Postnatal maternity services inpatient population estimates of women who received intimate partner violence (IPV) routine enquiry intervention (April–June 2017)

IPV Routine Enquiry, Disclosure and Referral Rates	Number	95% CI
Eligible women admitted to service	**11,229**	
Estimated number of women who received an IPV routine enquiry	**5,965**	**5484, 6446**
Estimated number of women who disclosed IPV	**264**	**156, 373**
Estimated number of women who received referrals to specialist services	**232**	
To active (on site) specialist services: 204		
To passive (offsite) specialist services: 28		

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

CHILD HEALTH INPATIENT

Nationally, 20 DHBs provided data from 22 child health inpatient locations. They reported that a total of 12,988 children were admitted during the three-month audit period (1 April – 30 June 2017). Random sampling from the 22 locations resulted in 552 cases audited for the 2017 Snapshot.

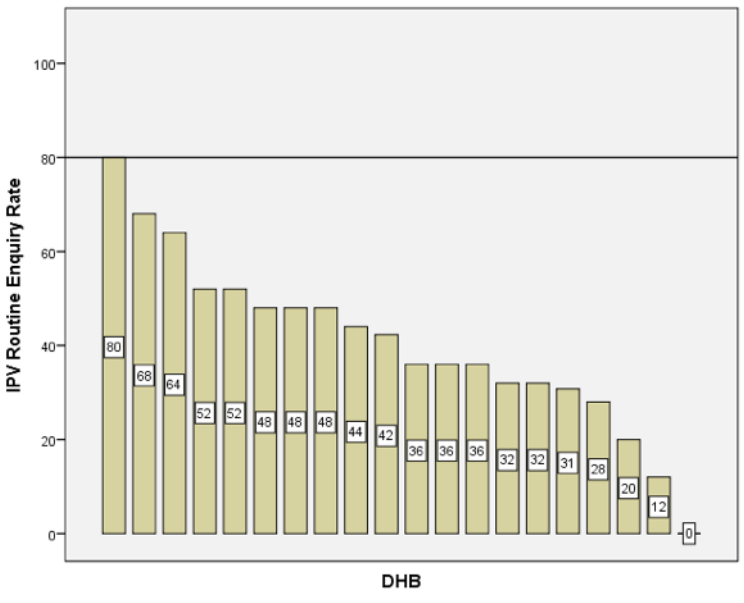


Figure 17. DHB child health 2017 (April–June) intimate partner violence routine enquiry rates

The IPV child health inpatient snapshot routine enquiry rate of female parents, guardians or caregivers, ranged from 0% to 80% (Figure 17). Taranaki DHB achieved the target IPV routine enquiry rate of 80%.

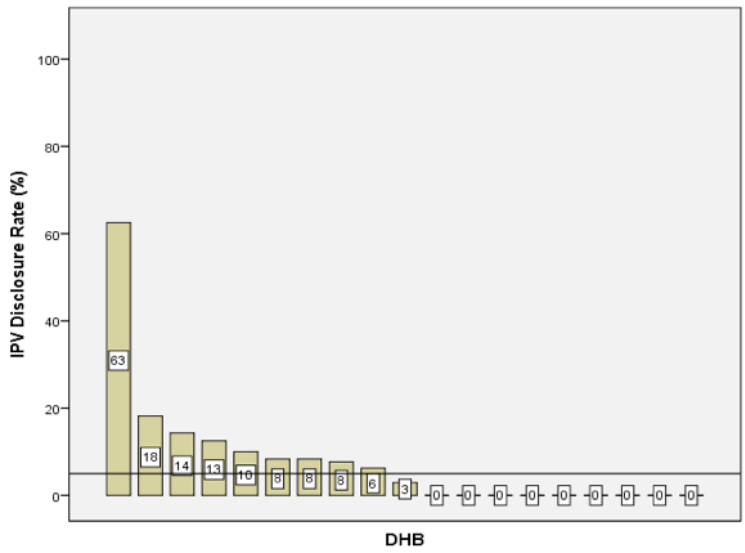


Figure 18. DHB child health 2017 (April–June) intimate partner violence disclosure rates

Among women who received an IPV routine enquiry, disclosure rates ranged from 0% to 63% across the 10 DHBs with a non-zero IPV routine enquiry rate (Figure 18). Nine DHBs met the expectation that at least one of every twenty women who received an IPV routine enquiry would disclose abuse. The DHBs were: Waitemata, Counties Manukau, Wairarapa, Hutt Valley, Taranaki, Tairawhiti, Bay of Plenty, Whanganui, and Nelson Marlborough.

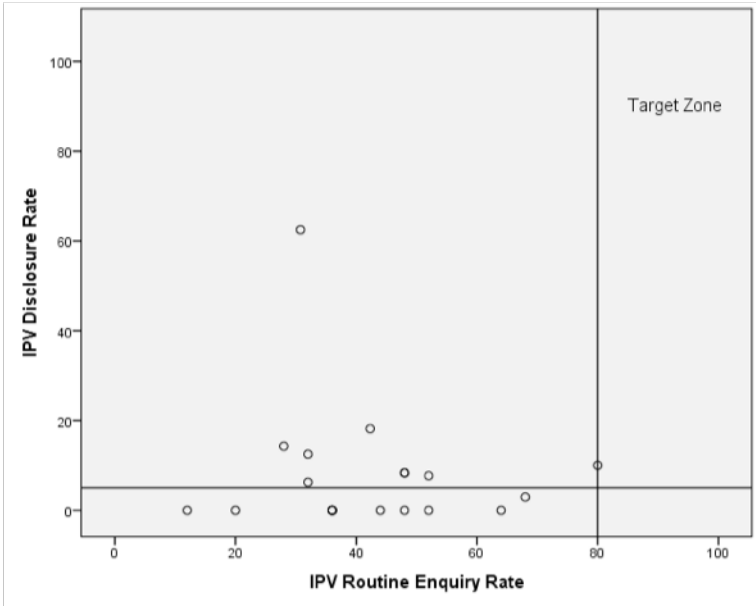


Figure 19. DHB child health inpatient 2017 (April–June) intimate partner violence routine enquiry and disclosure rates

Note: Some points include more than one DHB

In child health services, one DHB (Taranaki) achieved the benchmark (≥ 80% screening with ≥ 5% disclosure rate; Figure 19).

Based on the Snapshot weighted mean for IPV routine enquiry (39%; 95% CI 36%, 43%), we estimate that 5,118 female caregivers of children admitted to general paediatric wards during the second quarter of 2017 received a VIP intimate partner violence routine enquiry (see Table 10).

Based on the Snapshot data weighted mean for IPV disclosure (7%; 95% CI 5%, 9%), we estimate that 339 women disclosed IPV to a health care provider, with 255 women (69% of those who disclosed abuse) receiving a referral for specialist services.

Table 10. Child health inpatient population estimates of women who received intimate partner violence (IPV) routine enquiry and service (April–June 2017)

IPV Routine Enquiry, Disclosure and Referral Rates	Number	95% CI
Children admitted to service	**12,988**	
Estimated number of female caregivers who received an IPV routine enquiry	**5,118**	**4640, 5595**
Estimated number of female caregivers who disclosed IPV	**339**	**237, 441**
Estimated number of women who received referrals to specialist services	**255**	
To active (on-site) specialist services: 189		
To passive (off site) specialist services: 66		

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

EMERGENCY DEPARTMENT

Nationally, 20 DHBs provided data from 22 emergency departments. They reported that 101,320 women presented to the emergency departments during the three-month audit period (1 April – 30 June 2017). Random sampling from the 22 locations resulted in 574 cases audited for the 2017 Snapshot.

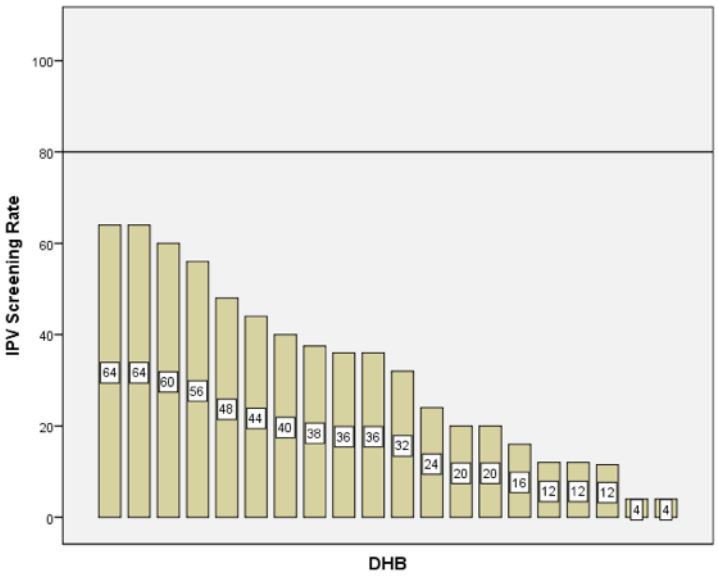
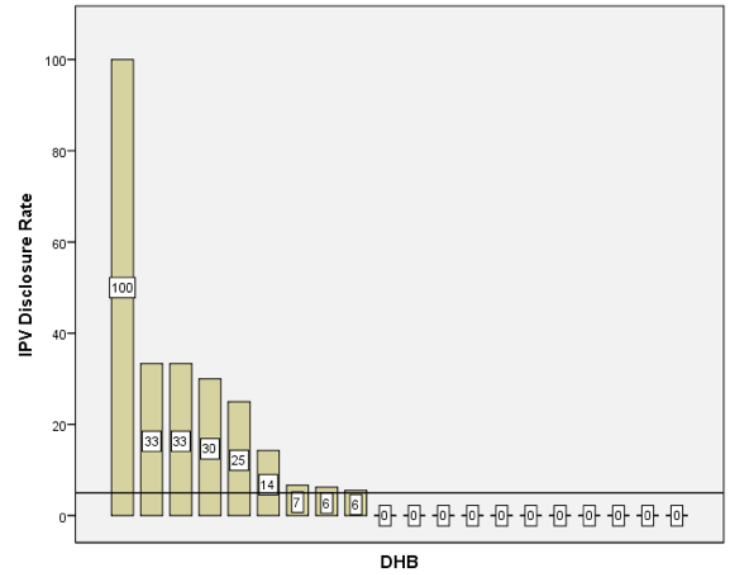


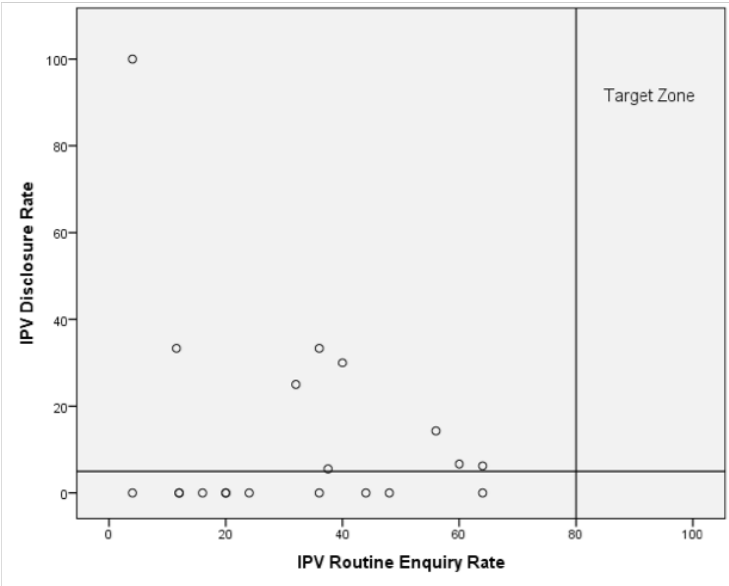
Figure 20. DHB emergency department 2017 (April–June) intimate partner violence routine enquiry rates

The IPV emergency department snapshot IPV routine enquiry rate of women aged 16 years and over ranged from 4% to 64% (Figure 20). One DHB has not implemented VIP in their service.



DHB IPV disclosure rates ranged from 0% to 100% (Figure 21). Nine DHBs (Waikato, Counties Manukau, Nelson Marlborough, Bay of Plenty, Taranaki, Tairawhiti, Whanganui, Canterbury and Auckland) met the expectation that at least one in every twenty women screened would disclose abuse.

Figure 21. DHB emergency department 2017 (April–June) intimate partner violence disclosure rates



In emergency department services, no DHBs achieved the benchmark (≥ 80% IPV routine enquiry with ≥ 5% disclosure rate; Figure 22). Two DHBS achieved an IPV routine enquiry rate over 60% with disclosure rates ≥ 5% (Canterbury and Tairawhiti). The single DHB with 100% disclosure rate had minimal routine enquiry and most likely represents a disclosure-related identification (level 1 identification) rather than routine screening.

Figure 22. DHB emergency department 2017 (April–June) intimate partner violence routine enquiry and disclosure rates

Note: Some points include more than one DHB

Based on the Snapshot weighted mean for IPV routine enquiry (30%; 95% CI 26%, 34%) we estimate that 30,330 women who presented to the adult emergency department during the second quarter of 2017 received a VIP intimate partner violence routine enquiry (see Table 11).

Based on the Snapshot data weighted mean for IPV disclosure (12%; 95% CI 9%, 15%) we estimate that 3,544 women disclosed intimate partner violence to a health care provider, with 2,418 women receiving a referral for specialist services.

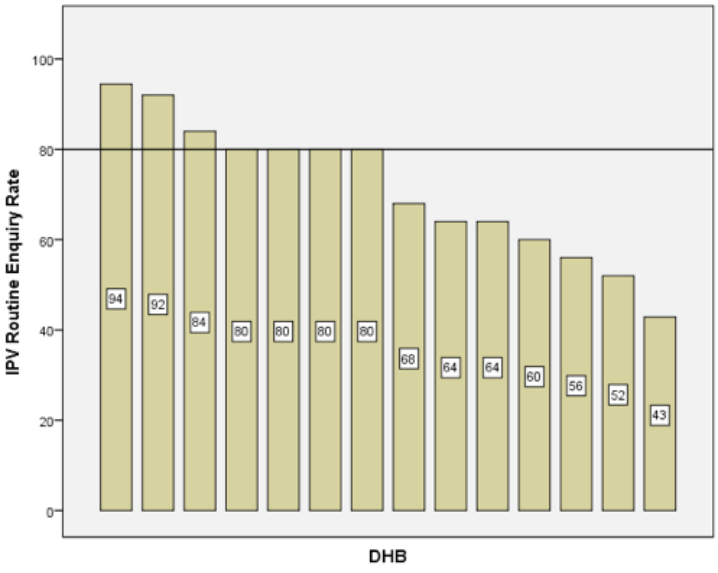
Table 11. Emergency department population estimates of women who received Intimate Partner Violence (IPV) routine enquiry and service (April–June 2017)

IPV Routine Enquiry, Disclosure and Referral Rates	Number	95% CI
Eligible women presenting to service	**101,320**	
Estimated number of eligible women who received an IPV routine enquiry	**30,330**	**26 418, 34 243**
Estimated number of eligible women who disclosed IPV	**3,544**	**2639, 4448**
Estimated number of women who received referrals*:	**2418**	
To active (onsite) specialist services: 1884		
To passive (off site) specialist services: 462		

Table notes: CI=Confidence Intervals; CIs not computed for referrals as cell sizes small; *= an additional 72 referrals made at Tairawhiti were not specified as to whether passive or active.

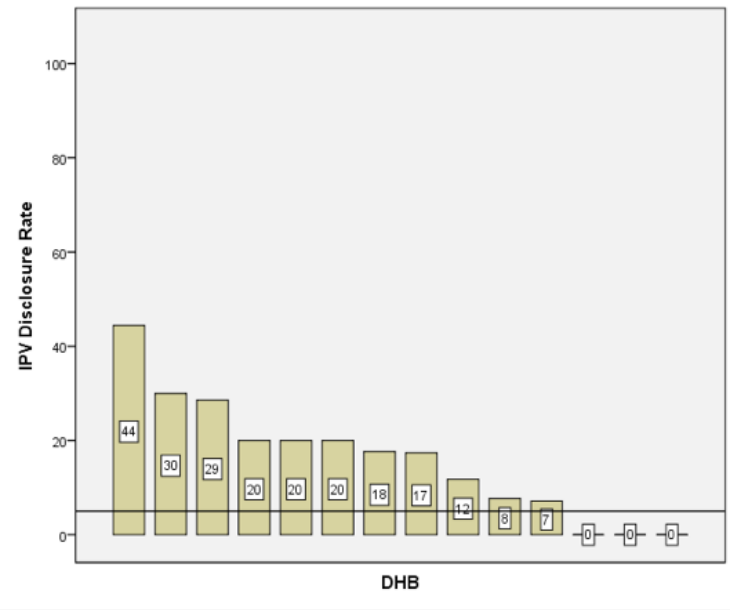
SEXUAL HEALTH SERVICES

Nationally, 93% (n=14) of DHBs providing sexual health services submitted Snapshot data in 2017. They reported that 6878 women presented to the sexual health service during the three-month audit period (1 April – 30 June 2017). Random sampling from the 14 locations resulted in 367 cases audited for the 2017 Snapshot.



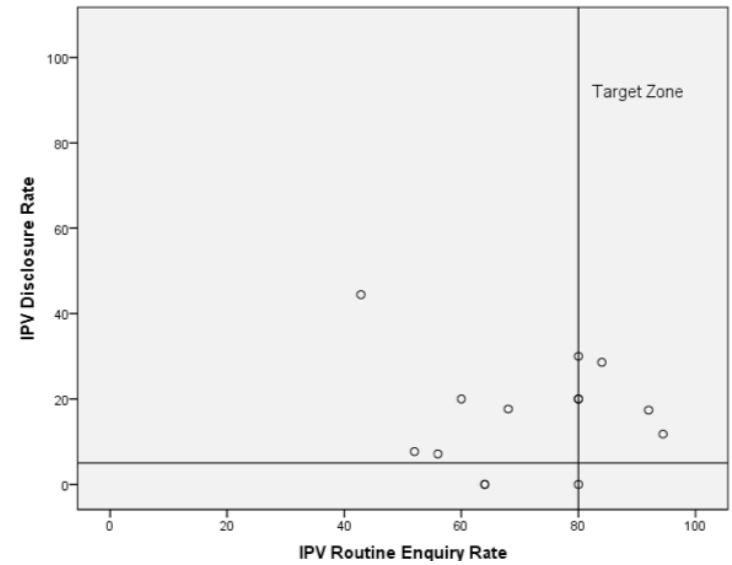
The IPV sexual health service Snapshot IPV routine enquiry rate for women aged 16 years and over ranged from 43% to 94% (Figure 23). Seven DHBs (Nelson Marlborough, Bay of Plenty, South Canterbury, Waikato, Tairawhiti, MidCentral and Canterbury) achieved the target IPV routine enquiry rate of greater than 80%.

Figure 23. DHB sexual health service 2017 (April–June) intimate partner violence routine enquiry rates (n=14)



IPV disclosure rates ranged from 0% to 44% (Figure 24). Eleven DHBs met the expectation that at least one in every twenty women screened would disclose abuse (Auckland, Canterbury, South Canterbury, Taranaki, Tairawhiti, MidCentral, Lakes, Bay of Plenty, Nelson Marlborough, Whanganui, and Northland).

Figure 24. DHB sexual health service 2017 (April–June) intimate partner violence disclosure rates (n= 14)



In sexual health services, six DHBs (Bay of Plenty, Nelson Marlborough, South Canterbury, MidCentral, Canterbury, and Tairawhiti) achieved the VIP Snapshot benchmark (≥ 80% IPV routine enquiry with ≥ 5% disclosure rate; Figure 25).

Figure 25. DHB sexual health service 2017 intimate partner violence routine enquiry and disclosure rates (n=14)

Note: Some points include more than one DHB

Based on the Snapshot weighted mean for IPV screening (67%; 95% CI 56%, 79%), we estimate that 4,643 women presenting to the sexual health services during the second quarter of 2017 received a VIP IPV routine enquiry (see Table 12).

Based on the Snapshot data weighted mean for IPV disclosure (19%: 95% CI 11%, 26%), we estimate that 860 women disclosed intimate partner violence to a health care provider, with 627 women receiving a referral for specialist services.

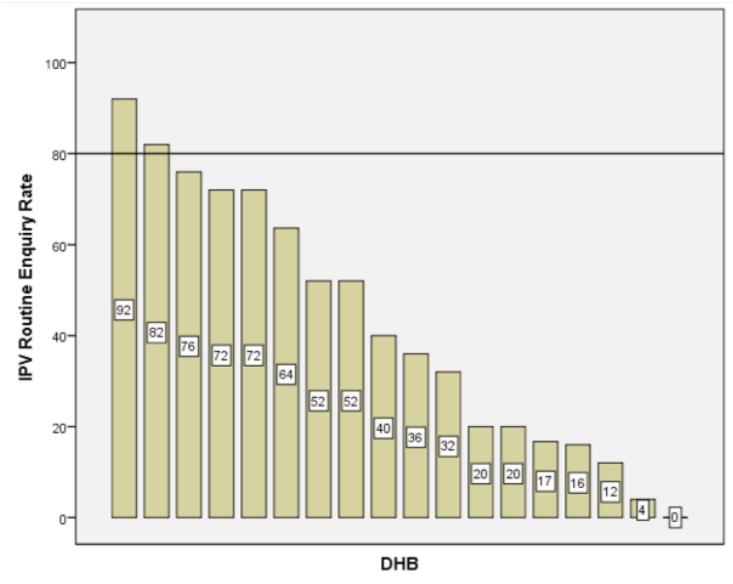
Table 12. Sexual health services population estimates of women who received intimate partner violence routine enquiry and service (April–June 2017)

IPV Routine Enquiry, Disclosure and Referral Rates	Number	95% CI
Eligible women admitted to service	**6878**	
Estimated number of women who received an IPV routine enquiry	**4,643**	**3835, 5450**
Estimated number of women who disclosed PA	**860**	**500, 1220**
Estimated number of women who received referrals:	**627**	
To active (onsite specialist services: 81		
To passive (off site) specialist services: 546		

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

COMMUNITY MENTAL HEALTH SERVICES

Nationally, 18 DHBs (90%) provided Snapshot data from 20 adult community mental health services in 2017. They reported that 6260 new women clients (seen for the first time by the service) and previous women clients (who had been discharged from and re-referred to the service (as if they were a new client)) aged 16 years and over presented to adult Community Mental Health Services during the three-month audit period (1 April – 30 June 2017). Random sampling from the 20 locations resulted in 493 cases audited for the 2017 Snapshot. The Ministry of Health released one DHB from the need to provide Snapshot data and one DHB did not provide data.



The IPV community mental health snapshot routine enquiry rate of women aged 16 years and over ranged from 0% to 92% (Figure 26). Two DHBs (MidCentral and Nelson Marlborough) achieved the target IPV routine enquiry rate of greater than 80%.

Figure 26. DHB community mental health service 2017 (April–June) intimate partner violence routine enquiry rates (n=18)

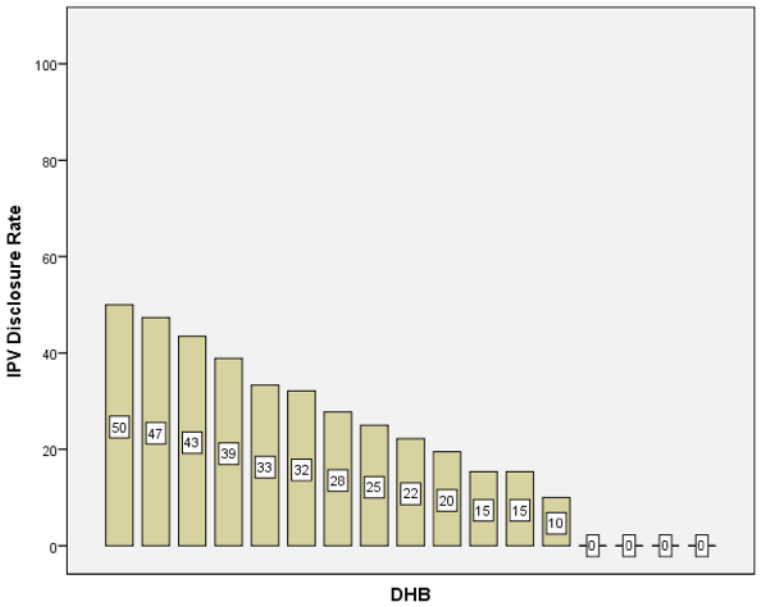


Figure 27. DHB community mental health service 2017 (April–June) intimate partner violence disclosure rates (n=17)

Among new women clients who received an IPV routine enquiry, in the 17 DHBs with a nonzero routine enquiry rate, IPV disclosure rates ranged from 0% to 50% (Figure 27). Thirteen DHBs (Taranaki, Bay of Plenty, MidCentral, Wairarapa, Lakes, Southern, Tairawhiti, West Coast, Nelson Marlborough, Whanganui, Counties Manukau, and Hawkes Bay) met the expectation that at least one in every twenty women who received an IPV routine enquiry would disclose abuse.

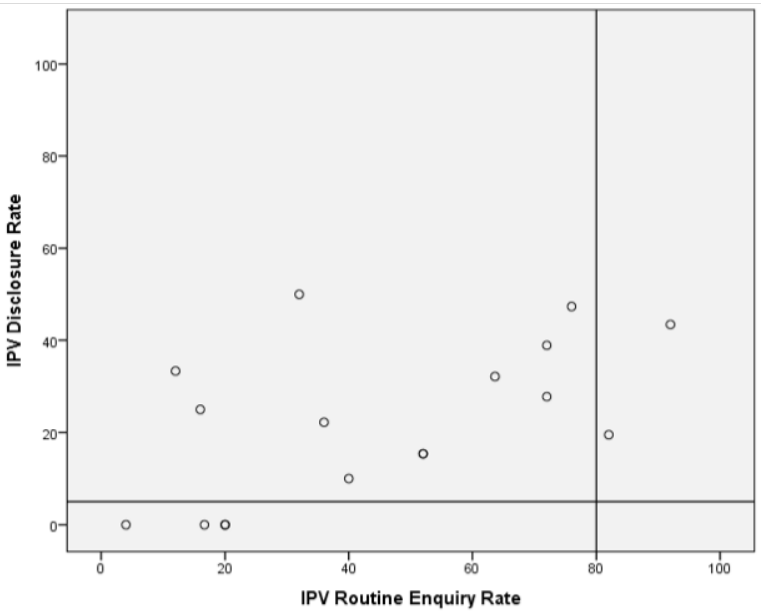


Figure 28. DHB community mental health service 2017 (April–June) intimate partner violence routine enquiry and disclosure rates (n=18)

Note: Some points include more than one DHB)

In adult community mental health services, two DHBs (MidCentral and Nelson Marlborough) achieved the benchmark (≥ 80% screening with ≥ 5% disclosure rate; Figure 28).

Based on the Snapshot weighted mean for IPV routine enquiry (40%; 95% CI 32%, 48%) we estimate that 2,482 women who presented to the adult community health service during the second quarter of 2017 received a VIP intimate partner violence routine enquiry (see Table 13).

Based on the Snapshot data weighted mean for IPV disclosure (28%%; 95% CI 22%, 34%) we estimate that 689 new women clients disclosed intimate partner violence to a health care provider, with 597 women receiving a referral for specialist services.

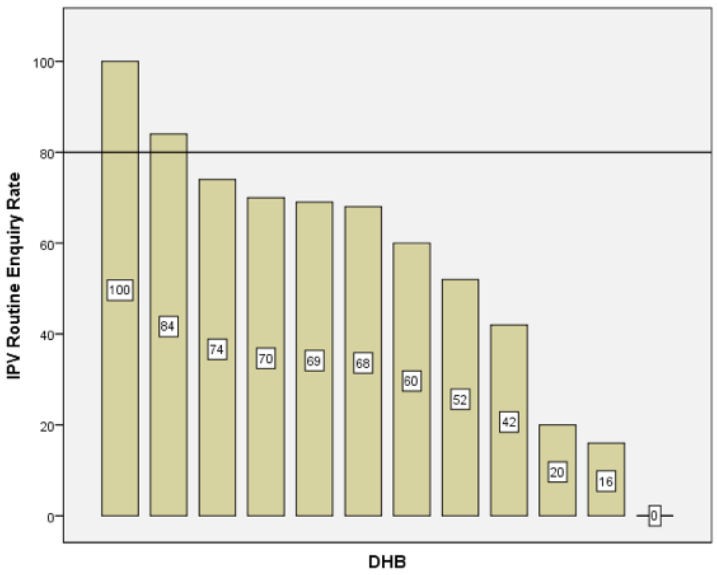
Table 13. Adult community mental health service population estimates of new women clients who received Intimate Partner Violence (IPV) routine enquiry and service (April–June 2017)

IPV Routine Enquiry, Disclosure and Referral Rates	Number	95% CI
Eligible women presenting to service	**6,620**	
Estimated number of eligible women who received an IPV routine enquiry	**2,482**	**1977, 2987**
Estimated number of eligible women who disclosed IPV	**689**	**538, 839**
Estimated number of women who received referrals:		
To active (onsite) specialist services: 381	**597**	
To passive (off site) specialist services: 216		

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

COMMUNITY ALCOHOL AND DRUG SERVICES

Nationally, 12 of the 16 DHBs providing community alcohol and drug services submitted Snapshot data in 2017. They reported that 1454 new women clients (seen for the first time who had completed at least one face to face contact) presented to community alcohol and drug services during the three-month audit period (1 April – 30 June 2017). Random sampling from the 12 locations resulted in 338 cases audited for the 2017 Snapshot. The Ministry of Health released one DHB from the need to provide Snapshot data and three DHBs did not provide data.



The IPV community alcohol and drug service Snapshot IPV routine enquiry rate for new women clients aged 16 years and over ranged from 0% to 100% (Figure 29). Two DHBs (MidCentral and Bay of Plenty) achieved the target IPV routine enquiry rate of greater than 80%.

Figure 29. DHB community alcohol and drug services 2017 (April–June) intimate partner violence routine enquiry rates (n=12)

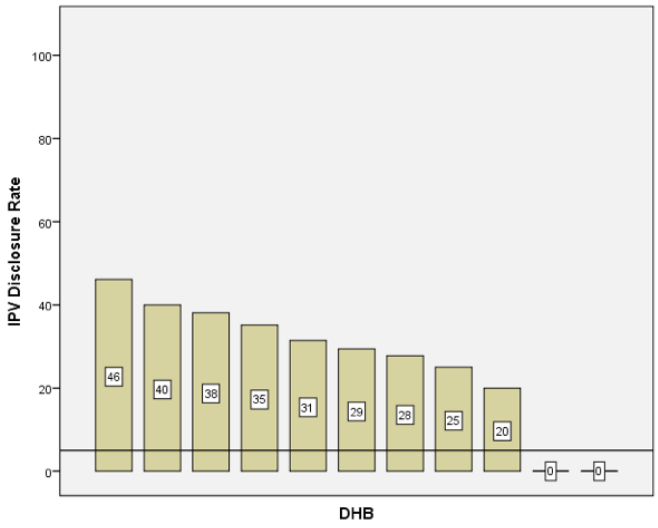


Figure 30. DHB community alcohol and drug services 2017 (April–June) intimate partner violence disclosure rates (n= 11)

IPV disclosure rates ranged from 0% to 46% (Figure 30). Nine DHBs met the expectation that at least one in every twenty women screened would disclose abuse (Taranaki, Canterbury, Bay of Plenty, Nelson Marlborough, Southern, Waitemata, Whanganui, Northland, and MidCentral).

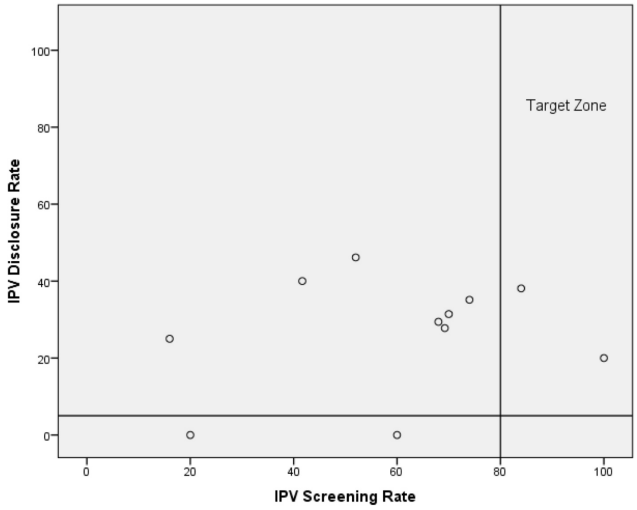


Figure 31. DHB community alcohol and drug services intimate partner violence routine enquiry and disclosure rates (n=11)

In community alcohol and drug services, two DHBs (MidCentral and Bay of Plenty) achieved the VIP Snapshot benchmark (≥ 80% IPV routine enquiry with ≥ 5% disclosure rate; Figure 31).

Based on the Snapshot weighted mean for IPV routine enquiry (61%%; 95% CI 47%, 76%), we estimate that 894 new women clients presenting to community alcohol and drug services during the second quarter of 2017 received a VIP IPV routine enquiry (see Table 14).

Based on the Snapshot data weighted mean for IPV disclosure (27%: 95% CI 19%, 35%), we estimate that 239 women disclosed intimate partner violence to a health care provider, with 175 women receiving a referral for specialist services

Table 14. Community alcohol and drug services population estimates of women who received intimate partner violence routine enquiry and service (April–June 2017)

IPV Routine Enquiry, Disclosure and Referral Rates	Number	95% CI
Eligible women admitted to service	**1454**	
Estimated number of women who received an IPV routine enquiry	**894**	**688, 1100**
Estimated number of women who disclosed IPV	**239**	**168, 311**
Estimated number of women who received referrals:	**175**	
To active (onsite) specialist services: 88		
To passive (off site) specialist services: 87		

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

CHILD ABUSE & NEGLECT ASSESSMENT & INTERVENTION

Nationally, 20 DHBs (100%) provided data from 22 emergency department locations. They reported that a total of 15,873 children under two years presented for any reason to the emergency department during the three-month audit period (1 April – 30 June 2017). Random sampling from the 22 locations resulted in 548 cases audited for the 2017 CAN Snapshot.

- In 2017, clinical assessment of children under two years of age presenting to an emergency department included a child protection screen for approximately four in ten (39%). This is an increase from 26% in 2016 (Figure 32 and Table 15).
- We estimate that approximately 600 children (601) presenting for emergency services during the three-month audit period in 2017 were assessed to have a child protection concern, all cases resulting in a specialist consultation.

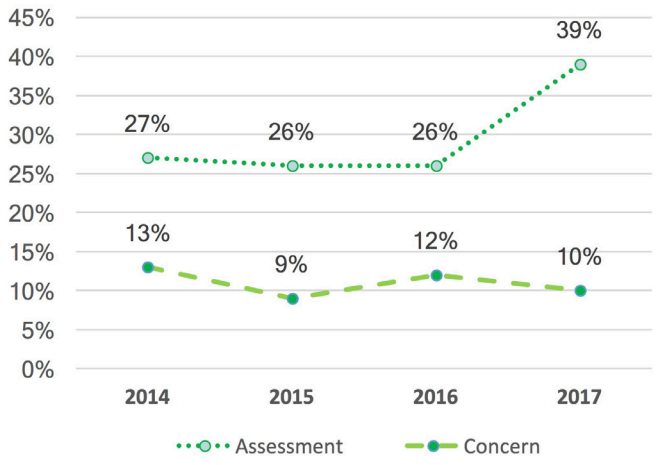


Figure 32. National child abuse & neglect assessment and concern rates (weighted means) for children under 2 years of age presenting to emergency departments (April–June, 2014 to 2017)

Table 15. Emergency department population estimates of children under two years of age who received child abuse and neglect (CAN) assessment and service (April – June, 2014 - 2017)

	Children assessed for CAN indicators				CP Concern (≥1 positive indicator)				Specialist Consultation			
	2014	2015	2016	2017	2014	2015	2016	2017	2014	2015	2016	2017
Population estimate	4163	4242	3404	6197	549	374	394	601	489	374	380	601
Weighted mean	27%	26%	26%	39%	13%	9%	12%	10%	89%	100%	93%	100%
95% CI	20%, 34%	21%, 32%	21%, 32%	33% 45%	8%, 18%	6%, 12%	8%, 15%	7% 13%	*	*	*	*

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

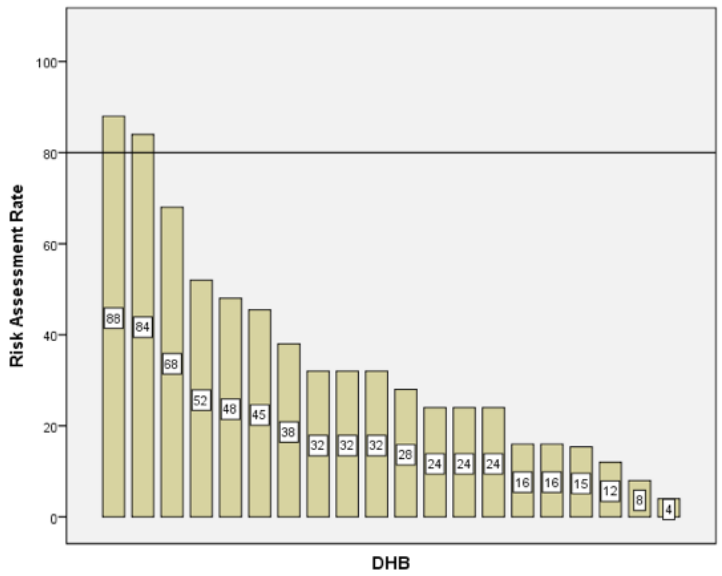
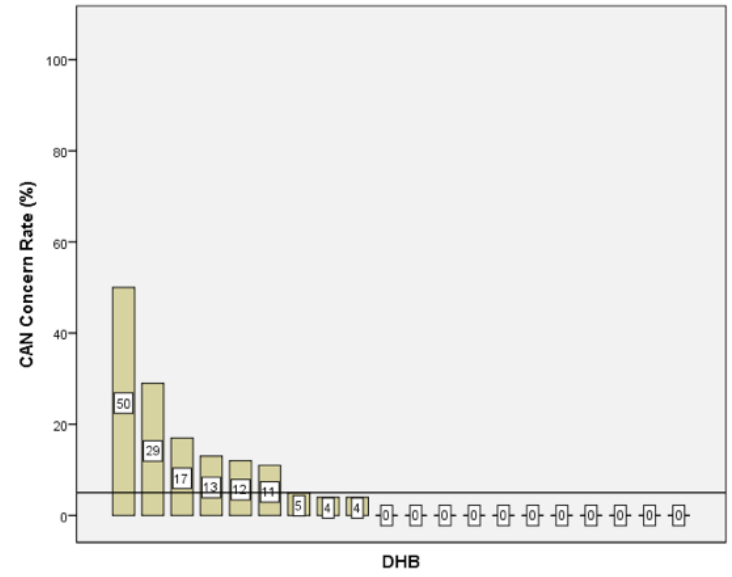


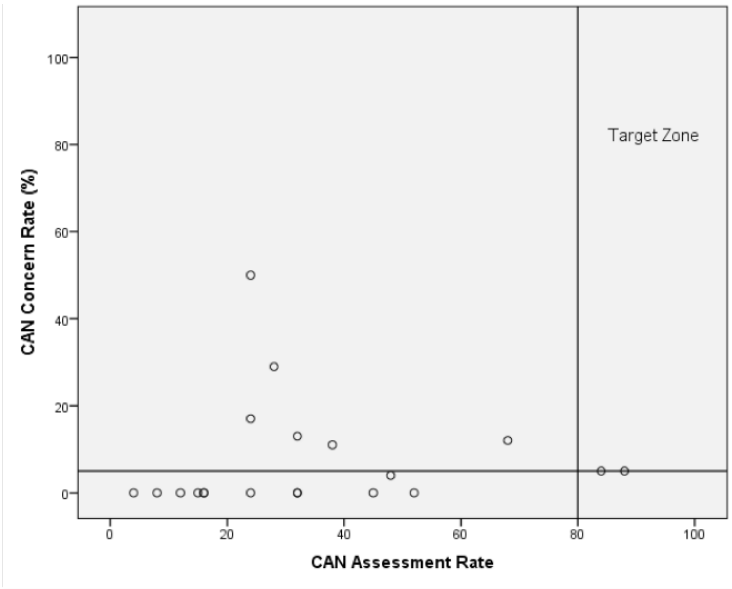
Figure 33. DHB emergency department 2017 (April–June) child abuse & neglect assessment rates for children presenting under 2 years of age

The child abuse and neglect Snapshot child protection assessment rate, for children under two presenting to emergency services for any reason, ranged from 4% to 88% across the DHBs (Figure 33). Two DHBs (Auckland and MidCentral) achieved the target assessment rate of greater than 80%.



All (n=20) DHBs had a child abuse and neglect assessment rate greater than zero. Of the children assessed, a child protection concern was identified in one or more children in 9 DHBs. Rates of identifying a child protection concern ranged from 0% to 50% (Figure 34). Seven DHBs had a concern rate of ≥ 5%.

Figure 34. DHB emergency department 2017 (April–June) child protection concern rates for children under 2 years of age



Two DHBs (Auckland and MidCentral) achieved a CAN assessment rate over 80% with a CAN concern rate of 5% or above (Figure 35 and Table 16).

Figure 35. DHB emergency department 2017 (April–June) child abuse and neglect assessment and concern rates for children under 2 years of age

Note: Some points include more than one DHB

Based on the Snapshot weighted mean for CAN assessment (39%; 95% CI 33%, 45%), we estimate that 6,197 children under two years of age seen in an acute hospital emergency department were assessed for abuse during the three-month audit period (see Table 16).

Based on the Snapshot data weighted mean for CAN identification of risk factors (10%; 95% CI 7%, 13%), we estimate that 601 children had a CAN concern identified with 601 (100%) children reviewed for child abuse and neglect by a specialist.

Table 16. Emergency Department population estimates of children under two years of age who received CAN assessment and service (April–June 2017)

IPV Routine Enquiry, Disclosure and Referral Rates	Number	95% CI
Children presenting to ED under 2 years for any reason	**15,873**	
Estimated number of children assessed for CAN indicators	**6,197**	**5278, 7115**
Estimated number of children with one or more positive CAN indicators	**601**	**418, 784**
Estimated number of children whose cases were reviewed for CAN with specialist	**601**	

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

ETHNICITY

Child abuse and neglect assessment rates for Māori and non-Māori children under 2 years of age presenting to an emergency department are displayed in Figure 35. Assessment rates for Māori and non-Māori children were similar in 2015 and 2017, though confidence intervals are wide (Table 17). Of note, improvement is necessary to achieve the target of assessing at least 80% of all children receiving care in emergency departments.

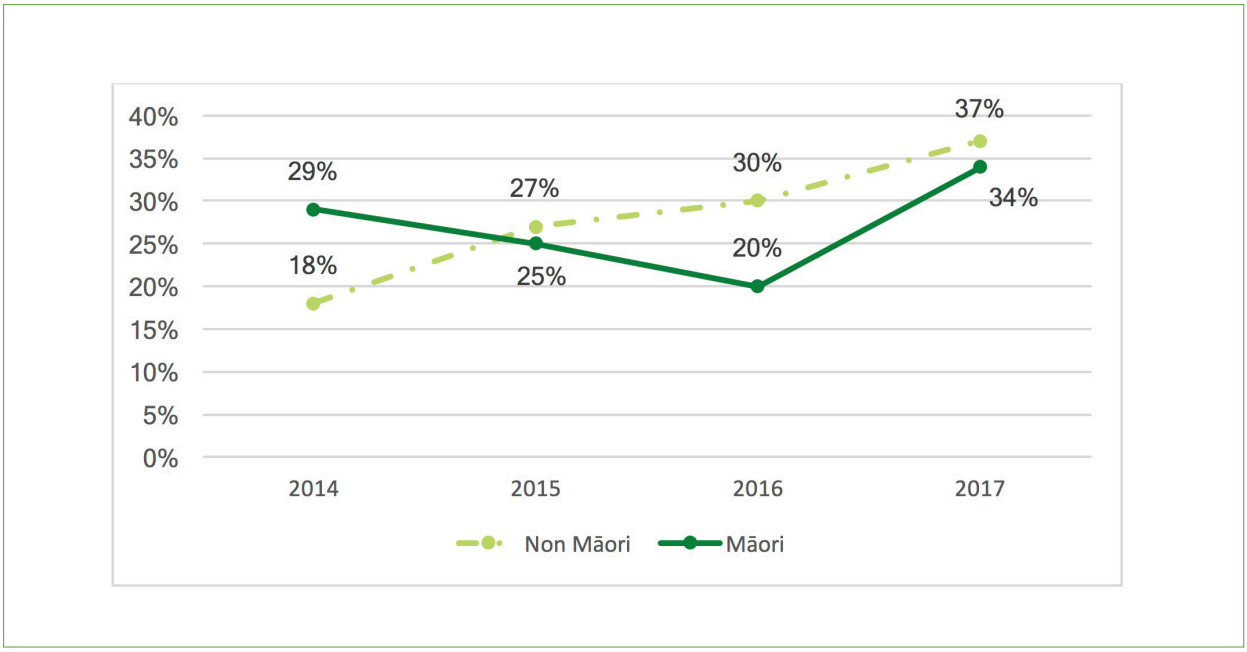


Figure 36. Child abuse and neglect assessments for children evaluated in the emergency department by ethnicity (Māori, non-Māori) (April-June quarter, 2014 – 1017)

Table 17. Child abuse and neglect assessment rates by ethnicity for children under two years of age presenting to the emergency department (April-June quarter, 2014-2017)

CAN Assessment	2014		2015		2016		2017	
	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori
CAN Assessment/ Reviewed	72/391	50/175	107/392	45/183	110/396	27/147	138/373	51/151
%	18%	29%	27%	25%	30%	20%	37%	34%
(95% CI)			(23%, 32%)	(18%, 31%)	(25%, 34%)	13%, 25%)	(32%, 42%)	(26%, 41%)

Note: These are crude rates over all DHB reported data and not adjusted for ethnic variation across DHBs. (95% Confidence Interval)

Intimate partner violence assessment rates were also examined for Māori and Non-Māori (Table 18). The greatest differences in assessment rates between Māori and non-Māori in 2017 were evident in community mental health services, with Māori under-assessed (absolute difference of 8%), and in alcohol and drug services where Māori were assessed at an 8% higher rate than non-Māori. Similar to assessment for child abuse and neglect, both Māori and non-Māori are under-served (less than 80% assessment rates).

Table 18. IPV assessments by ethnicity

IPV Routine Enquiry	2014		2015		2016		2017	
	Non Māori	Māori	Non Māori	Māori	Non Māori	Māori	Non Māori	Māori
Postnatal Maternity	160/429 37%	53/120 44%	229/439 52% (47%, 57%)	60/137 44% (35%, 52%)	238/433 55% (50%, 60%)	67/120 56% (47%, 65%)	243/434 56% (51%, 61%)	55/110 50% (41%, 59%)
Child Health Inpatients	266/429 37%	110/336 33%	142/374 38% (33%, 43%)	73/169 43% (36%, 51%)	154/377 46% (41%, 52%)	52/149 40% (31%, 49%)	151/377 40% (35%, 45%)	57/147 39% (31%, 49%)
Emergency Department	N/A	N/A	118/447 26% (22%, 31%)	26/104 25% (17%, 33%)	117/408 29% (24%, 33%)	26/93 28% (19%, 37%)	135/410 33% (28%, 37%)	27/88 31% (21%, 41%)
Sexual Health	N/A	N/A	164/277 59% (53%, 65%)	69/101 68% (59%, 78%)	172/262 66% (60%, 71%)	43/79 54% (43%, 66%)	202/275 73% (68%, 79%)	60/89 67% (57%, 77%)
Alcohol & Drug	N/A	N/A	N/A	N/A	96/199 50% (43%, 57%)	46/101 46% (36%, 55%)	143/257 56% (50%, 62%)	52/81 64% (54%, 75%)
Community Mental Health	N/A	N/A	N/A	N/A	144/302 48% (42%, 53%)	41/87 47% (36%, 58%)	164/345 48% (42%, 53%)	49/122 40% (31%, 49%)

Note: These are crude rates over all DHB reported data and not adjusted for the ethnic variation across DHBs. Child Health Inpatient in 2015 excludes 7 cases where there was no documentation of no female caregiver; 2015, 2016 and 2017 (,) = 95% confidence interval.

FINDINGS: QUALITY IMPROVEMENT AND PDSA CYCLES

DHBs submitted 21 completed PDSAs in 2016, and 15 in 2017. Many (n=17) PDSAs addressed improving child protection assessment rates in the emergency department for children under the age of two years. Improving IPV routine enquiry of female caregivers in Child Health (n=9) and of adult women in the emergency department (n=8) were also common.

Other PDSAs objectives included introduction of Strangulation Guidelines into the ED, upskilling and clarifying the role of VIP champions, supporting staff post-training, setting up VIP internal websites, education for new mothers in postnatal maternity and family violence resource booklets to supplement training.

In reviewing PDSAs, we identified the following issues:

- In most cases, the 2017 results were an improvement on the 2016 results.
- Plans to include the IPV or CAN assessment documentation into the electronic patient record usually resulted in significant delays beyond the control of the VIP team.
- Submitted cycle timeframes were substantially longer (up to 12 months) than would normally be associated with PDSAs (e.g. two weeks).
- Submitted plans were often too complex.
- Gaining buy in from key players, relationship building, collaboration and planning always took longer than expected and support was not always forthcoming in the timeframe expected.
- Unexpected positive benefits could also accrue to services when working with the VIP team. (For example, in one DHB, realised that mental health assessments did not include assessing for children in the family and changes were made to include children in case management strategies.)
- Not all DHBs focused on core VIP outputs (improving CAN or IPV assessment or intervention consistency or quality).
- PDSAs should focus on one test of change at a time, using sequential cycles to achieve improvement goals.

DISCUSSION

The VIP evaluation aims to (a) measure programme infrastructure indicators, (b) measure service delivery consistency and quality in Ministry of Health targeted services and (c) foster system improvements. The health response to family violence is directed by national assessment and intervention guidelines[1,2,44] and supported by a health systems approach.[10–12] VIP continues to be aligned to government initiatives to reduce child abuse and neglect and intimate partner violence.

Many developments have occurred within DHBs to support an improved response to family violence. In 2016 and 2017, DHBs focused on implementing the 2016 *Family Violence Assessment and Intervention Guideline: Child Abuse and Intimate Partner Violence*.[2] This involved updating policies and training. In 2017, all 20 DHBs have exceeded the programme infrastructure benchmarks (Delphi tool scores) that were set in 2015. The Delphi tool has now been revised and will set a new aspirational target for the future.

Clinical Snapshot data evidences that best practice is possible, with some service locations achieving the target assessment rate of ≥ 80% for CAN Child Protection or IPV and the target disclosure or identification of concern rate of ≥ 5%. Currently, however, these locations are the minority, with significant system variation. More improvements in service delivery are needed. Monitoring service delivery continues to be challenging in itself. Most DHB programmes are dependent on paper files for their data monitoring, making it a time-consuming process. Standardised digitalisation of family violence indicators would increase efficiency and promote shifting effort from monitoring to testing system improvements.

As stated in 2016, having data is only a first step in improving quality. Understanding the "causes underlying the differences and determining what actions may be appropriate to take to improve health outcomes"[45] remains a challenge. Organisational theory is useful to consider conditions necessary for best practice, and those that can undermine best practice. Birken notes both internal organisation and external environment influence practice.[46] There are likely to be many reasons why some of the barriers to the Violence Intervention Programme's full and sustainable integration into the business of DHBs have not been removed. At the same time, the introduction of DHB senior leadership, ownership and accountability for the VIP as the weightiest domain of the revised Delphi tool is consistent with evidence that organisational climate for innovation is a predictor of family violence service delivery.[47] The inclusion of a cultural responsiveness domain, in addition to items throughout the tool, that focuses on the health response to family violence for Māori, may help reduce inequities within the system. Integrating client and community feedback into programming remains a key indicator in the revised Delphi tool.

The response to family violence is not a tick box affair. It demands a supportive system with a skilled workforce sensitive to the dynamics of family violence, including the entanglement between intimate partner violence and child abuse and neglect and the family harm caused by a pattern of coercive and controlling behaviours.[48,49] This is essential if we are to meet our obligation to prevent and reduce the harm of family violence.[50] The Violence Intervention Programme is continuing to evolve, informed by infrastructure and practice-based evidence, to meet this challenge.

EVALUATION STRENGTHS AND LIMITATIONS

Strengths of this evaluation project include using established family violence programme evaluation instruments and following standard quality improvement processes in auditing.[19,51] Evaluation procedures are based on a philosophy of supporting programme leaders in building a culture of improvement.[19,32] The project promotes a comprehensive systems approach to addressing family violence, a key characteristic for delivering effective services.[10]

The audit rounds foster a sense of urgency,[52] supporting timely policy revisions, procedure endorsements and FVI Coordinator position vacancies. Finally, and perhaps most importantly, the longitudinal nature of the evaluation has allowed monitoring of change over time (2004 to 2017). The addition of clinical Snapshot audits in 2014 provides standardised data aggregated across DHBs for accountability and performance measurement.

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

Limitations are important to consider in interpreting the findings and making recommendations based on this evaluation work. By design, this study is limited to DHBs providing acute hospital and community services at secondary and tertiary public hospitals. The VIP does not include services provided by private hospitals, which may also provide publicly funded services, or primary care where family violence prevention programmes are being introduced opportunistically in DHB regions. Limitation of the current VIP are also carried over to this evaluation, for example, neither the Ministry of Health Guideline, nor this evaluation work, addresses the health response to those who have a pattern of using controlling, coercive behaviours. Finally, specific limitation to the clinical Snapshot audit include:

- The Snapshot audit does not capture all recommended family violence assessment and intervention, such as for male patients presenting with signs or symptoms indicative of abuse or services provided in the primary care setting.
- The Snapshot sample size for individual DHBs is small (n=25). For example, a DHB may have assessed for abuse in 15 out of 25 eligible cases (60%, 95% confidence interval) with a single abuse disclosure (1/15, 6.7%, 95% confidence interval). Individual DHB estimates are therefore considered indicative of service delivery.
- The Snapshot audit monitors a limited number of service delivery indicators, sensitive to the burden of manual medical record review. Not captured, for example, is the graduated health response based on assessed level of risk.
- There remain some service locations yet to fully implement VIP: (a) Emergency Department – Auckland DHB; (b) Sexual Health – South Canterbury systems do not capture FV screening information; (c) Alcohol & Drugs – Waikato DHB and (d) Community Mental Health Services – Waikato DHB. In addition, three DHBs did not submit full Snapshot data: (a) Alcohol & Drugs – South Canterbury, Tairawhiti, West Coast; (b) Community Mental Health Services – South Canterbury; and (c) Sexual Health – West Coast.

VIP PRIORITIES

- THE VIP is fully implemented in all Ministry of Health targeted services in all DHBs
- DHBs use the Model for Improvement to improve the consistency and quality of identification, assessment, and intervention for children, women, their families and whānau experiencing family violence.
- Establish a new programme infrastructure benchmark for DHBs.
- Standardise national IT solutions to enable electronic monitoring of VIP by DHB services.
- Continue to contribute to and support government initiatives and interventions to reduce child abuse and neglect and intimate partner violence.

REFERENCES

1. Fanslow J. *Family Violence Intervention Guidelines: Child and Partner Abuse*. Wellington, New Zealand: Ministry of Health;2002.
2. Fanslow J, Kelly P. *Family violence assessment and intervention guideline: Child abuse and intimate partner violence.* 2nd ed. Wellington: Ministry of Health; 2016.
3. Adams A, Tolley A. Progress on the work programme for the Ministerial Group on Family Violence and Sexual Violence: Cabinet paper Wellington, NZ: Office of the Minister of Justice and Office of the Minister for Social Development; 2015.
4. New Zealand Government. Delivering Better Public Services: Supporting Vulnerable Children Result Action Plan. 2012. http://www.msd.govt.nz/documents/about-msd-and-our-work/work-programmes/better-public-services/supporting-vulerable-children/supporting-vulnerable-children-result-action-plan. pdf. Accessed 18.12.2013.
5. Ministry of Health. Statement of Intent 2014–2018: Ministry of Health. Wellington: Ministry of Health; 2014.
6. Young-Wolff KC, Kotz K, McCaw B. Transforming the health care response to intimate partner violence: Addressing "wicked problems". *JAMA*. 2016;315(23):2517–2518.
7. Decker MR, Frattaroli S, McCaw B, et al. Transforming the healthcare response to intimate partner violence and taking best practices to scale. *Journal of women's health (2002)*. 2012;21(12):1222–1229.
8. Bell E, Butcher K. *DFID Guidance Note on Addressing Violence Against Women and Girls in Health Programmes-Part B*. London: VAWG Helpdesk, Department for International Development;2015.
9. World Health Organization. Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies. Geneva: World Health Organization; 2010: http://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf.
10. García-Moreno C, Hegarty K, d'Oliveira AFL, Koziol-McLain J, Colombini M, Feder G. The health-systemsresponse to violence against women. *The Lancet*. 2014;385(9977):1567–1579.
11. 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. *Soc Sci Med*. 2011;72(6):855–866.
12. 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. *J Paediatr Child Health*. 2008;44(3):92–98.
13. Solberg LI, Mosser G, McDonald S. The three faces of performance measurement: improvement, accountability, and research. *Jt Comm J Qual Improv*. 1997;23(3):135–147.
14. Nolan T, Resar R, Haraden C, Griffin FA. *Improving the Reliability of Health Care*. Cambridge, MA: Institute for Healthcare Improvement;2004.
15. Spangaro J, Koziol-McLain J, Zwi A, Rutherford A, Frail MA, Ruane J. Deciding to tell: Qualitative configurational analysis of decisions to disclose experience of intimate partner violence in antenatal care. Soc Sci Med. 2016;154:45–53.
16. Feder G, 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.
17. Fanslow J, Robinson E. Violence against women in New Zealand: prevalence and health consequences. NZ Med J. 2004;117(1206):U1173.
18. Ministry of Justice. 2014 *New Zealand Crime and Safety Survey Main Findings*. Wellington New Zealand: Ministry of Justice;2015.
19. Langley GJ, Moen RD, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*. 2nd ed. San Francisco: Jossey-Bass; 2009.

20. Guedes A, Bott S, Garcia-Moreno C, Colombini M. Bridging the gaps: a global review of intersections of violence against women and violence against children. *Glob Health Action.* 2016;9:31516.

21. Dobbs T, Eruera M. *Kaupapa Māori wellbeing framework: The basis for whānau violence prevention and intervention* Auckland, New Zealand: New Zealand Family Violence Clearinghouse;2014.

22. World Health Organisation. *Preventing child maltreatment: a guide to taking action and generating evidence.* Geneva, Switzerland: WHO; 2006.

23. United Nations Children's Fund. *Hidden in Plain Sight: A statistical analysis of violence against children.* New York: UNICEF;2014.

24. World Health Organization. *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines.* Geneva, Switzerland: World Health Organization;2013.

25. Wilson D, Koziol-McLain J, Garrett N, Sharma P. A hospital-based child protection programme evaluation instrument: A modified Delphi study. *Int J Qual Health Care.* 2010;22(4):283-293.

26. Koziol-McLain J, Adams J, Neitzert E, et al. *Hospital Responsiveness to Family Violence: Baseline Audit Findings.* Auckland: Auckland University of Technology;2004. Commissioned by the New Zealand Ministry of Health.

27. Coben J. Measuring the quality of hospital-based domestic violence programs. *Acad Emerg Med.* 2002;9(11):1176-1183.

28. Jigsaw, Ministry of Health. *Increasing VIP Programmes' Responsiveness to Māori: A whānau-centred approach for the VIP programme.* Wellington, NZ: Ministry of Health;2014.

29. New South Wales Health. *Domestic Violence Routine Screening Snapshot Report 11 (2013).* Sydney Australia: NSW Kids and Families;2014.

30. New Zealand Government. Vulnerable Children's Act, No. 40. 2014.

31. Durie M, Cooper R, Grennell D, Snively S, Tuaine N. *Whānau Ora: Report of the Taskforce on Whānau-Centred Initiatives.* Wellington: Ministry of Social Development;2010.

32. Massoud MR, Donohue KL, McCannon CJ. Options for *Large-scale Spread of Simple, Highimpact Interventions. Technical Report.* Bethesda, MD: University Research Co;2010.

33. Agency for Healthcare Research and Quality. Evaluating Domestic Violence Programs. 2002; http://www.ahrq.gov/research/domesticviol/. Accessed 02.01.2013.

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

35. Koziol-McLain J, Garrett N, Gear C. *Hospital responsiveness to family violence: 48 month follow-up evaluation* Auckland, NZ: Interdisciplinary Trauma Research Unit, Auckland University of Technology;2009. ISSN 1177-4347 Report No 8.

36. Ettorchi-Tardy A, Levif M, Michel P. Benchmarking: A Method for Continuous Quality Improvement in Health. *Healthcare Policy.* 2012;7(4):e101-e119.

37. Koziol-McLain J, Gardiner J, Batty P, Rameka M, Fyfe E, Giddings L. Prevalence of intimate partner violence among women presenting to an urban adult and paediatric emergency care department. *N Z Med J.* 2004;117(1206):U1174.

38. Whitehead A, Fanslow J. Prevalence of family violence amongst women attending an abortion clinic in New Zealand. A*ust N Z J Obstet Gynaecol.* 2005;45(4):321-324.

39. Koziol-McLain J, Rameka M, Giddings L, Fyfe E, Gardiner J. Partner violence prevalence among women attending a Māori health provider clinic. Aust N Z J Public Health. 2007;31(2):143-148.

40. Koziol-McLain J, Garrett N, Fanslow J, et al. A Randomized Controlled Trial of a Brief Emergency Department Intimate Partner Violence Screening Intervention. *Ann Emerg Med.* 2010;56(4):413-423.

41. Ansara DL, Hindin MJ. Formal and informal help-seeking associated with women's and men's experiences of intimate partner violence in Canada. *Soc Sci Med.* 2010;70(7):1011-1018.

42. World Health Organization. *Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence.* Geneva: World Health Organization Press;2013. ISBN 978 92 4 156462 5.

43. MInistry of Health. *Ethnicity Data Protocols for the Health and Disability Sector.* Wellington, NZ: Ministry of Health;2004.

44. Glasgow K, Fanslow J. Family Violence Intervention Guidelines: *Elder Abuse and Neglect.* Wellington: Ministry of Health;2007.

45. Nolte E. *International benchmarking of healthcare quality: A review of the literature.* Cambridge, UK: RAND Europe and London School of Hygiene and Tropical Medicine;2010.

46. Birken SA, Bunger AC, Powell BJ, et al. Organizational theory for dissemination and implementation research. *Implement Sci.* 2017;12(1):62.

47. Allen NE, Larsen SE, Javdani S, Lehrner AL. Council-based approaches to reforming the health care response to domestic violence: promising findings and cautionary tales. *Am J Community Psychol.* 2012;50(1-2):50-63.

48. Family Violence Death Review Committee. *Fifth Report: January 2014 to December 2015.* Wellington: New Zealand Health Quality & Safety Commission;2016.

49. Wilson D, Smith R, Tolmie J, de Haan I. Becoming better helpers: Rethinking language to move beyond simplistic responses to women experiencing intimate partner violence. Policy Quarterly. 2015;11(1):25-31.

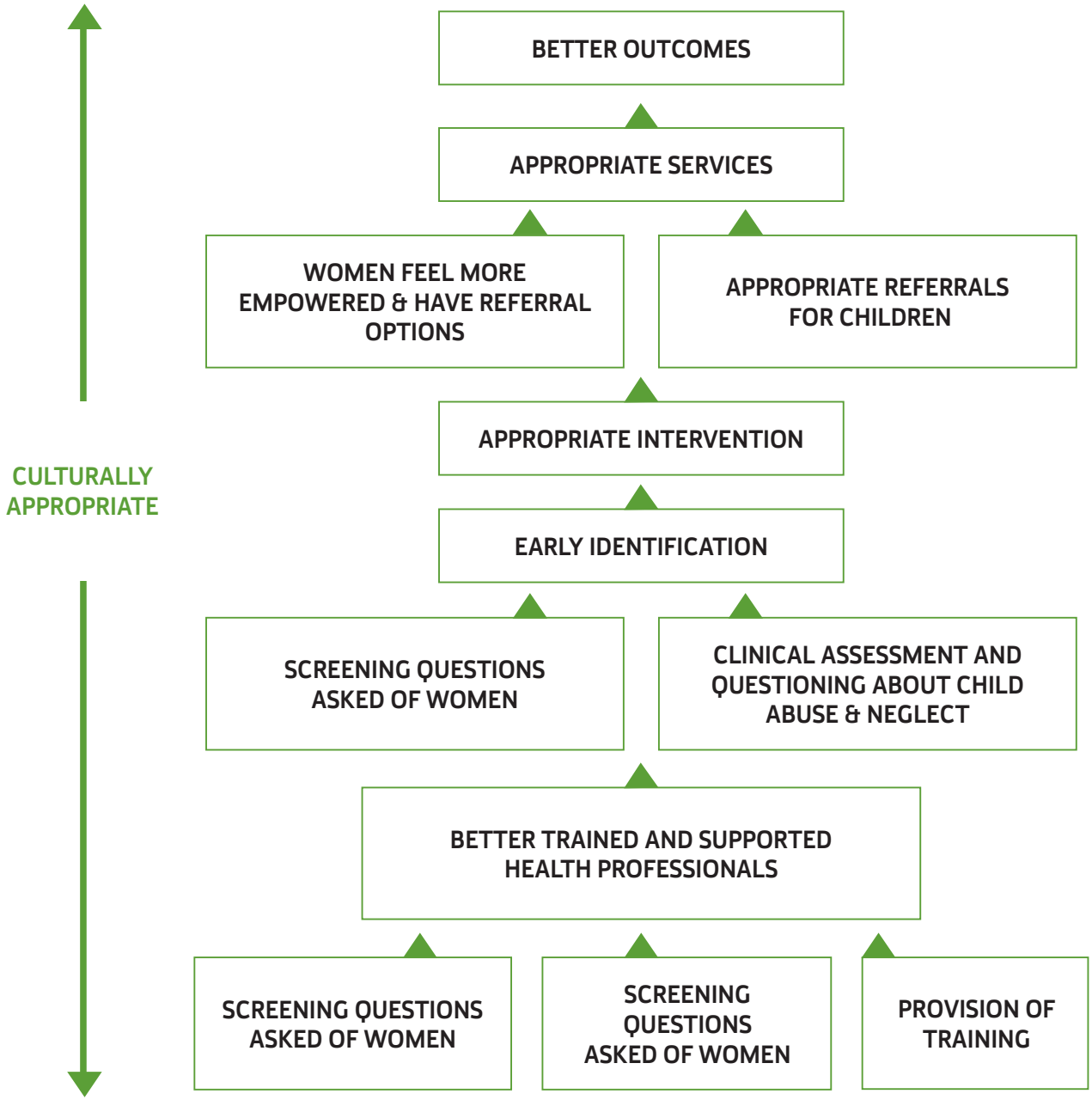
50. United Nations Entity for Gender Equality and the Empowerment of Women, World Health Organization, United Nations Population Fund, United Nations Development Programme, United Nations Office on Drugs and Crime. *Essential Services Package for Women and Girls Subject to Violence*. New York2015.

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

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

APPENDICES

APPENDIX A: FAMILY VIOLENCE PROGRAMME LOGIC



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

APPENDIX B: DISTRICT HEALTH BOARD HOSPITALS

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

S = secondary service, **T** = tertiary

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

APPENDIX C: VIP SNAPSHOT AUDIT INFORMATION SHEET

VIP Snapshot Information 2016 and 2017

1. Introduction

The VIP Snapshot clinical audit system has been developed to provide an efficient and user-friendly audit tool.

2. Overview

The VIP Snapshot's primary purpose is to provide measurement data of DHB VIP Intimate Partner Violence (IPV) and Child Abuse and Neglect (CAN) assessment and intervention delivery in selected services.

VIP snapshot clinical audits indicate a shift in national VIP evaluation focus from DHB infrastructure development to accountability and improvements in the delivery of services to vulnerable children, women, their whānau and families.

3. Timeframe

The due date is 10 October 2016.

4. 2016 VIP Snapshot Clinical audit

Two new services, Adult general Community Mental Health Services (including Kaupapa Māori Community Mental Health clinical services) and Alcohol and Drug Services have been added to the 2016 VIP Snapshot Clinical audit. Please see details in Appendix 1.

Therefore, seven DHB services are to be included in the 2016 VIP snapshot audit.

a. Intimate Partner Violence (IPV):

- Postnatal Maternity Admissions
- Adult Emergency Department
- Child Health inpatient (aged 0–16 years) – Female guardians, parents or caregivers assessed for IPV
- Sexual Health services
- Adult general Community Mental Health Services
- Alcohol & Drug Services

b. Child Abuse and Neglect Assessment:

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

5. Sites

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

6. Audit Period

The 3-month Snapshot audit period is from 1 April to 30 June 2016.

7. User names and Passwords

Please contact either Arlene Advani (Arlene.advani@aut.ac.nz) or Chris McLean (Christine.McLean@aut.ac.nz) if you require a user name and/or password for the VIP Snapshot system. If you have forgotten your password, we will issue you with a temporary one.

Access the VIP Snapshot system at https://vipsnapshot.aut.ac.nz

8. Random Sample

The first step in selecting a random sample is to identify all eligible persons during the review period (1 April – 30 June) for each of the seven services listed above. From those eligible, random samples of 25 patient health records are to be retrospectively selected for each service.

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

9. Definitions

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

10. Adhoc and Official Audits

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

11. Start a New Audit

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

12. Enter patient data

1. Click Ethnicity/ies as recorded in the patient file
2. IPV Routine Enquiry / Child Protection Assessment – Yes/No

a. If tick No, save and move onto next patient file.

b. If tick yes, go to IPV Disclosed / Child Protection Concern

i. If tick no, save and move onto next patient file

ii. If tick yes, go to IPV Referral /CAN Consultation

1. Tick Yes or No, save and move onto next patient.
3. The number of files entered and saved appears on the right side of the screen.
4. 25 patient files to be entered for each service.
5. Please check that the system automatically switches over to audit status "DONE" for Official (required Snapshot Audit) when input is complete. (If not, please click "In Progress" to switch over to DONE.) Adhoc (voluntary) audits need to be manually switched over by clicking "In Progress" to "DONE").

6. You may enter the data in one or more sittings. The system will keep track of how many patients you have entered.
7. If you are entering a smaller number of cases for an ad hoc audit you may click the "In Progress" button to change to "DONE".

13. Your Results

The system will provide the DHB results (screening (routine enquiry or assessment) and disclosure/concern and referral/consultation). Document your results for each service in your January 2017 report to the Ministry of Health.

APPENDIX 1. VIP SNAPSHOT AUDIT DEFINITIONS

Generic Questions:

VIP Core Training:	Enter the percent of current staff who have completed VIP Core Training in designated service
Ethnicity:	Select Ethnicity/ies as indicated in patient file
Total number eligible:	Total number of women (or children) who meet eligibility criteria for the specific service during audit period. See specific service below for criteria.

IPV Routine Enquiry:

IPV Routine Enquiry:	**Was the woman asked routine enquiry questions about IPV occurring in the past 12 months?**
NO:	There is no documentation that the woman was asked routine enquiry questions. If there is documentation regarding a reason for not asking routine enquiry questions (such as 'with partner'), this is still a 'NO'.
YES:	There is documentation that the woman was asked routine enquiry questions about IPV occurring within the past 12 months. This would include asking the woman three or more routine enquiry questions about IPV*.

* Reference to three or more routine enquiry questions is explicated in the DHB family violence policy/protocol document.

IPV Disclosed:	**Did the woman disclose IPV?**
NO:	Woman did not disclose IPV. If a woman was asked routine enquiry questions about IPV, but there is no documentation regarding disclosure, this is a 'NO'.
YES:	Woman disclosed abuse occurring within the past 12 months. If woman disclosed abuse before being asked routine enquiry questions about IPV, would still be a 'YES'.

IPV Referrals: Were appropriate referrals made?

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

YES: ACTIVE: Direct referral to timely access for support by a family violence trained specialist who can provide the victim with danger assessment, safety planning and access to community services. (The trained specialist may include for example, police, social worker, or family violence advocate.)

YES: PASSIVE: Evidence in notes of appropriate referrals to specialised family violence support. This would include, for example, providing the woman with a brochure with contact information.

Note: In Child Health Inpatients, the female parent, guardian or caregiver is assessed for IPV. If no female caregiver, the IPV routine enquiry is a NO.

IPV – Service specific information

Postnatal Maternity

Eligibility Criteria: Women who have given live birth and who have been admitted to postnatal maternity ward during audit period.

Adult Emergency Department

Eligibility Criteria: Women aged 16 years and over who presented to ED during the audit period.

Age: Enter age of woman

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

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

Sexual Health

Eligibility Criteria: Women aged 16 years and over who present to Sexual Health Services during the audit period

Child Health Inpatient

Eligibility Criteria: Child health admissions aged 16 years and under, admitted to a general paediatric inpatient ward (not a specialty setting) during the audit period

No female caregiver Documentation states there is no female caregiver. If there is no female caregiver, the response to IPV routine enquiry question is NO.

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

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

IPV Routine Enquiry: Was the female caregiver (parent, guardian or caregiver) asked routine enquiry questions about IPV occurring in the past 12 months?

Community Alcohol & Drug Services

Eligibility Criteria: New women clients (seen for the first time by the service) aged 16 years and over who presented to Community Alcohol and Drug Services during the audit period.

Record Review: For randomly selected clients, record review to be conducted for the index visit and up to two subsequent visits if occurring within two months of the initial index visit. (For example, if client seen in April, review may extend through June; if client seen in June, review may extend through August).

Adult General Community Mental Health Services

Service Definition: General adult community mental services includes Kaupapa Māori, community, adult, non-residential mental health services.

It would not include Mental Health Specialist services (e.g. Community Adolescent Mental Health, Maternal Mental Health, Crisis Team, CAT (Crisis Assessment and Treatment) teams or residential services.

Eligibility Criteria: New women clients (seen for the first time by the service) aged 16 years and over who presented to adult general Community Mental Health Services for the first time during the audit period.

Sampling: If fewer than 25 new clients during the three-month audit period, include them all in the audit.

Record Review: For randomly selected clients, record review to be conducted for the index visit and up to two subsequent visits if occurring within two months of the initial index visit. (For example, if client seen in April, review may extend through June; if client seen in June, review may extend through August).

Child Abuse & Neglect

Eligibility Criteria: Children aged under 2 years presenting to the Emergency Department for any reason during the audit period

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

Thorough Child Protection Assessment - Was a Child Protection Assessment done?

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

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

CAN Concern – Was a Child Protection Concern identified?

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

CAN Consultation:	**Were identified Child Protection concerns discussed?**
NO:	No indication of discussion in the notes about Child Protection risk factors and assessment, or the plan appears inappropriate, unclear or misleading, or notes indicate clear plan but do not indicate who the case was discussed with. If no CAN concern, this is a 'NO'.
YES:	Evidence that Child Protection consultation occurred is in the notes with name and designation of person consulted. Child Protection Consultation may be with a Senior Consultant ED, Paediatrician, specialist social worker, CYF, or another member of the multidisciplinary child protection team. Discussion of the Child Protection risk factors, assessment of the level of risk and plan is recorded.

APPENDIX 2. VIP SNAPSHOT AUDIT REFERENCES

- Fanslow J L, Kelly P, Ministry of Health. 2016. Family Violence Assessment and Intervention Guideline: Child abuse and intimate partner violence (2nd edn). Wellington: Ministry of Health.
- Langley, G. J., Moen, R. D., Nolan, K. M., Nolan, T.W., Norman, C. L. & Provost, L. P. (2009). The improvement guide: A practical approach to enhancing Organisational Performance. San Francisco, CA: Jossey-Bass.
- O'Campo, P., Kirst, M., Tsamis, C., Chambers, C., Ahmad, F. (2011) Implementing successful intimate partner violence screening programs in health care settings: Evidence generated from a realist-informed systematic review. Social Science & Medicine, 72, 855-866. Doi: 10.1016/j.socscimed.2010.12.019
- Perla, R. J., Bradford, D. A. (2011) Balancing Cost and Precision in Hospital Accountability Sampling. J Healthc Qual, May-Jun; 33(3), 5-9. Doi: 10.1111/j.1945-1474.2010.00106.x. Epub 2010 Jul 23.
- Solberg, L. I., Mosser, G., & McDonald, S. (1997). The three faces of performance measurement: Improvement, accountability and research. The Joint Commission on Quality Improvement, 23, 135-147.
- Wilson, D., Smith, R., Tolmie, J., de Haan, I. (2015). Becoming Better Helpers. Rethinking language to move beyond simplistic responses to women experiencing intimate partner violence.

APPENDIX D: DHB SELF AUDIT REPORT: 2016 FOLLOW-UP FORM

Violence Intervention Programme (VIP) Evaluation

Self Audit Report: 2016 (for the period 1 July 2015 – 30 June 2016)

NOTE: This report was not used in 2017 as this information is available from the Ministry of Health through the District Health Board VIP 6 monthly Progress Reports.

**** District Health Board**

**** Hospital(s)**

**** ** 2016**

Chief Executive Officer

VIP Sponsor / Portfolio Manager

FVIC

Child Protection Coordinator

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

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

DHB Violence Intervention Programme Self Audit Summary

This report provides an analysis based on review of the following (tick all that apply):

____Current VIP strategic plan and 2015-16 action plan

____Partner Abuse Programme Overall and Category Scores (using Delphi tool)

____Child Abuse and Neglect Programme Overall and Category Scores (using Delphi tool)

____VIP Snapshot Clinical Audit results (using online Snapshot findings)

____Internal clinical audit results (using VIP QI Toolkit)

____2015-2016 completed PDSA cycles

____Completed Supplementary Information (see page 4)

Self Audit Findings and Observations

Most significant VIP achievements since the last audit:

Programme Strengths

Areas for Improvement:

Overall Audit Conclusions:

[Consider: Evaluation scores, VIP Snapshot results, Māori Responsiveness, Progress since previous audit, and Proposed Actions for 2016]

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

1.

2.

Self Audit Report Approval:

DHB Violence Intervention Programme Audit Team Leader

Name Signature Review Date

DHB Violence Intervention Programme Sponsor

Name Signature Review Date

SUPPLEMENTARY INFORMATION

(Please complete and submit with self audit report)

1. Cultural responsiveness to Māori and contribution to Whānau Ora workforce development

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

---

2. Elder Abuse and Neglect intervention and violence prevention policies

Have Elder Abuse and Neglect (EAN) policies been approved? YES / NO (delete one)

Are the policies being implemented? YES / NO (delete one)

---

3. Disability initiatives

Has your programme addressed issues for persons with disabilities? and family violence?

YES / NO (Delete one)

---

4. Shaken Baby Programme Implementation

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

---

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

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

Comments:

APPENDIX E: DELPHI SCORING WEIGHTS

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

The weightings used for this study are provided below.

Domain	Partner Abuse	Child Abuse & Neglect	Revised Child Abuse & Neglect
1. Policies & Procedures	1.16	1.16	1.21
2. Physical Environment	0.86	0.86	0.95
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 & Security	N/A	N/A	1.20

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

APPENDIX F: EVALUATION PREPARATION INFORMATION 2016 & 2017

CENTRE FOR INTERDISCIPLINARY TRAUMA RESEARCH
AUT UNIVERSITY

VIP violence intervention programme

VIP EVALUTION PEPARATION INFORMATION (2017)

Introduction

The VIP evaluation provides the opportunity for DHBs to build competence in family violence service delivery as well as measure progress over time. Processes are guided by a philosophy of supporting programme leaders in building a culture of improvement. The evaluation project is approved by the Multi-region Ethics Committee (AKY/03/09/218) with current approval to December 2016.

It is recommended that requirements of the 2016 VIP audit are completed in the following order.

1 ***VIP Delphi Infrastructure Self Audit in Partner Abuse & Child Abuse & Neglect***

2 ***VIP Snapshot clinical audits for Intimate Partner Violence in:***

Postnatal Maternity

Child Health Inpatients

Adult Emergency Department

Sexual Health Services

Community Alcohol & Drug Services

Adult General Community Mental Health Services

AND FOR CHILD ABUSE AND NEGLECT IN

Children under the age of two years presenting to the Emergency Department for any reason

3 ***Two Model for Improvement Plan-Do-Study-Act (PDSA) plans for quality improvement initiatives***

The 2017 VIP evaluation covers the one-year period 1 July 2016 to 30 June 2017. The Snapshot clinical audits cover a three-month period 1 April 2017 to 30 June 2017.

We are currently finalising a new VIP Assessment Systems and Practice (VIP-ASAP) tool which will replace the current VIP Delphi tools for the 2017 – 2018 evaluation. Your DHB may be invited to participate in pilot testing this tool. This tool will enhance VIP infrastructure evaluation by ensuring that the domains and indicators meet best practice elements of a health response informed by current literature, New Zealand health context, local practice, New Zealand Ministry of Health Family Violence Assessment and intervention Guidelines (2016) and expanding programmes.

Three DHBs have been randomly selected to participate in external independent audits (involving a site visit).

Information that has previously been reported in the 'VIP DHB Programme Evaluation Self-Report' will be abstracted from the Ministry of Health (MoH) VIP Performance Monitoring Report. This will reduce duplicate reporting burden. The Ministry expect the Delphi and Snapshot audit findings, and PDSA improvements submitted to AUT, to be referenced in the January 2018 DHB Performance Monitoring Report.

Dates

6 October 2017	VIP Delphi Audits for Partner Abuse and Child Abuse and Neglect
	VIP Snapshot Audits for 7 services – data entry to be completed
	Two PDSA – PLANS only – for evaluation team review
14 November 2017	Preliminary 2016 VIP Audit results will be shared at the NNVIPC meeting in Christchurch
10 December 2017	Two completed PDSA worksheets (with DO, STUDY and ACT) due
15 December 2017	Final Cut Off for receipt of any outstanding audit documentation from DHBs

Evaluation Preparation

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

- Making an Audit Plan 2017
- Gathering Evidence for your Audit (including the physical environment walk through form)

1 *VIP Delphi Infrastructure Self-Audits*

- Preparation for the Delphi excel tool audits should build on previous audit documentation, updating and improving evidence collation.
- Collate evidence of all achieved indicators
- Reference evidence location (such as policy title, date and page number) in the evidence columns of the excel audit tools (refer to 'Gathering Evidence for your Audit' as attached)
- Please double check that all items have been answered
- If required, blank partner abuse and child abuse and neglect audit files are available to download at www.aut.ac.nz/vipevaluation or from the VIP HIIRC website.
- Please submit your PA and CAN Delphi audits to Arlene Advani (Arlene.advani@aut.ac.nz) by 6 October.

External independent audits (selected DHBs only)

External independent audits for selected DHBs will involve review of self-audit Delphi, Snapshot and PDSA processes and evidence. The purposes of the visits are to assess self-audit rigour and to support the DHB VIP team in building a culture of improvement.

2 *VIP Snapshot Clinical Audits*

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

- Sample size: Retrospective random samples of 25 patient health records are to be selected from the 3-month review period – 1 April to 30 June 2017 from 7 services:

  IPV:

  - Postnatal Maternity
  - Child Health Inpatient
  - Sexual Health Services
  - Adult Emergency Department
  - Community Alcohol and Drug
  - Adult General Community Mental Health Services, including Kaupapa Māori Community Mental Health clinical services

  CAN:

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

- Please contact Arlene Advani (arlene.advani@aut.ac.nz) to organise registration and passwords for new users. You will be issued with a temporary password and will be required to create a password for the system
- If you have forgotten your password, please log in using your DHB user name. The system will ask if you've forgotten your password and issue you with a temporary one. You will be required to create a password for the system.
- Access the VIP Snapshot system at https://vipsnapshot.aut.ac.nz
- Medical Records should be advised as soon as possible of the audit requirements for each service
- Please enter your VIP Snapshot data by 6 October 2016

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

- Two PDSA Plans are to be submitted by 10 October for review and approval by the AUT evaluation team
- The Objectives should focus on improving your Snapshot results.
- PDSA pack with resources and instructions will be forwarded separately (and available on HIIRC).
- Completed PSDA worksheets (with DO, STUDY and ACT) submitted by 10 December 2016.

ADDITIONAL INFORMATION

DHB VIP information previously reported in the VIP DHB Programme Evaluation Self Audit Report will be abstracted from the Ministry of Health (MoH) VIP Performance Monitoring Report. This will reduce duplicate reporting burden. The Ministry expect that the Delphi and Snapshot audit findings, and PDSA improvements submitted to AUT, will be referenced in the January 2018 DHB Performance Monitoring Report.

National Report. A national report and summary documenting VIP programme development across the audit period will be made available by June 2018. Audit discussions and individual DHB reports provided by auditors will be kept confidential between the DHB and MOH VIP team. National reports of overall programme and cultural responsiveness scores will identify DHBs in league tables. DHBs achieving high scores in the VIP Snapshot audits will be named in the National Report.

Audit Support

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

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

Christine McLean

Research Project Manager

Centre for Interdisciplinary Trauma Research
School of Clinical Sciences
Auckland University of Technology

cmclean@aut.ac.nz

Professor Jane Koziol-McLain, PhD, RN

Principal Investigator

Centre for Interdisciplinary Trauma Research
School of Clinical Sciences
Auckland University of Technology

jkoziolm@aut.ac.nz

CENTRE FOR INTERDISCIPLINARY TRAUMA RESEARCH
AUT UNIVERSITY

VIP violence intervention programme

VIP AUDIT PREPARATION INFORMATION

2016 EVALUATION

Introduction

The VIP evaluation provides the opportunity for DHBs to build competence in family violence service delivery as well as measure progress over time. Processes are guided by a philosophy of supporting programme leaders in building a culture of improvement. The evaluation project is approved by the Multi-region Ethics Committee (AKY/03/09/218) with current approval to December 2016.

It is recommended that requirements of the 2016 VIP audit are completed in the following order.

1

VIP Delphi Infrastructure Self Audit in

Partner Abuse &

Child Abuse & Neglect

2

VIP Snapshot clinical audits for Intimate Partner Violence in:

Postnatal Maternity

Child Health Inpatients

Adult Emergency Department

Sexual Health Services

Community Alcohol & Drug Services

Adult General Community Mental Health Services

AND FOR CHILD ABUSE AND NEGLECT IN

Children under the age of two years presenting to the Emergency Department for any reason

3 *Self Audit Report*

4 *Two Model for Improvement Plan-Do-Study-Act (PDSA) Worksheets for 2016/2017*

The 2016 VIP audit covers the one-year period 1 July 2015 to 30 June 2016 (not to be confused with the Snapshot audit three-month period from 1 April to 30 June 2016).

Due Dates

10 October 2016	VIP Delphi Audits
	VIP Snapshot Audits – data entry to be completed
	Self Audit Report
	Two PDSA – PLANS only –due for evaluation team review
10 April 2017	Two completed PDSA worksheets (with DO, STUDY and ACT) due

Preliminary 2016 VIP Audit national results will be shared at the NNVIPC Meeting (14 November in Tauranga)

Audit Preparation

We encourage the development of an Audit Plan to guide your evaluation processes. The plan is ideally developed in collaboration with the DHB VIP portfolio manager, steering group (including Quality & Risk, Māori Health) and Family Violence Intervention Coordinator(s). The following resource may assist you in effective self audit planning: Making an Audit Plan 2016 (Making a Self-Audit Plan 2016.pdf).

1 *VIP Delphi Infrastructure Self-Audits*

- Preparation for the Delphi excel tool audits should build on previous audit documentation, updating and improving evidence collation.
- If required, blank partner abuse and child abuse and neglect audit files are available to download at www.aut.ac.nz/vipevaluation or from the VIP HIIRC website.
- A Physical Environment Walk Through Form is also available (VIP Physical environment walkthrough.pdf)
- Please submit your PA and CAN Delphi audits to Christine McLean by 10 October.

2 *VIP Snapshot Clinical Audits*

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

- Sample size: Retrospective random samples of 25 patient health records are to be selected from the 3-month review period – 1 April to 30 June 2016 from 7 services:

  IPV:

  - Postnatal Maternity
  - Child Health Inpatient
  - Sexual Health Services
  - Adult Emergency Department
  - Community Alcohol and Drug
  - Adult General Community Mental Health Services, including Kaupapa Māori Community Mental Health clinical services

  CAN:

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

- Please contact Arlene Advani (arlene.advani@aut.ac.nz) to organise registration and passwords for new users. You will be issued with a temporary password and will be required to create a password for the system
- If you have forgotten your password, please log in. The system will ask if you've forgotten your password and issue you with a temporary one. You will be required to create a password for the system.
- Access the VIP Snapshot system at https://vipsnapshot.aut.ac.nz
- Medical Records should be advised as soon as possible of the audit requirements for each service
- Snapshot audits are to be undertaken in all services whether or not VIP is implemented
- Please enter your VIP Snapshot data by 10 October 2016

3 *Self Audit Reportts*

- Two PDSA Plans are to be submitted by 10 October for approval by the AUT Evaluation Team prior to implementation
- The Objectives should focus on improving your Snapshot results.
- PDSA pack with resources and instructions will be forwarded separately.
- Completed PSDA worksheets (with DO, STUDY and ACT) submitted by 10 April 2016.

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

- Two PDSA Plans are to be submitted by 10 October for approval by the AUT Evaluation Team prior to implementation
- The Objectives should focus on improving your Snapshot results.
- PDSA pack with resources and instructions will be forwarded separately.
- Completed PSDA worksheets (with DO, STUDY and ACT) submitted by 10 April 2016.

ADDITIONAL INFORMATION

Independent Audit

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

National Report

A national report and summary documenting VIP programme development across the audit period will be made available in July 2017. Audit discussions and individual DHB reports provided by auditors will be kept confidential between the DHB and MOH VIP team. National reports of overall programme and cultural responsiveness scores will identify DHBs in league tables. DHBs achieving high scores in the VIP Snapshot audits will be named in the National Report.

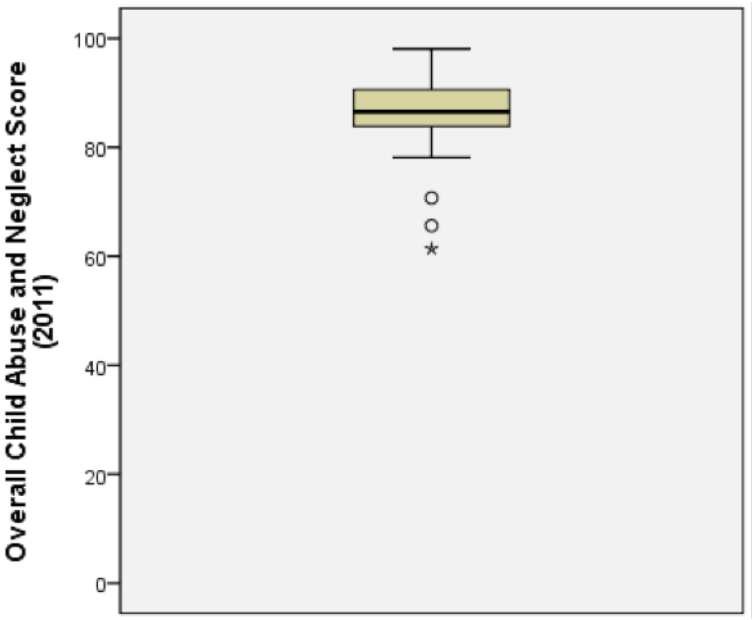
Audit Support

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

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

Christine McLean	**Professor Jane Koziol-McLain, PhD, RN**
Research Project Manager	Principal Investigator
Centre for Interdisciplinary Trauma Research School of Clinical Sciences Auckland University of Technology	Centre for Interdisciplinary Trauma Research School of Clinical Sciences Auckland University of Technology
cmclean@aut.ac.nz	jkoziolm@aut.ac.nz

APPENDIX G: HOW TO INTERPRET BOX PLOTS



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

APPENDIX H (A). INTIMATE PARTNER VIOLENCE DELPHI SUMMARY SCORES 2004 TO 2017

Median Scores	2004	2005	2007	2008	2009	2011	2012	2013	2014	2015	2016	2017
Overall Score	20	28	49	67	74	84	91	92	92	92	91	93
Domain Scores												
Policies & Procedures	19	30	49	62	75	82	87	89	87	87	91	90
Physical Environment	7	15	23	75	79	91	100	100	100	100	98	100
Institutional Culture	22	31	59	72	83	89	94	97	94	92	94	98
Training of Providers	11	32	59	78	88	89	100	100	100	100	100	100
Screening & Safety Assessment	0	0	43	65	73	80	80	85	87	88	88	88
Documentation	0	19	29	67	76	90	91	90	100	95	90	90
Intervention Services	26	46	62	65	79	93	100	100	97	99	97	100
Evaluation Activities	0	0	20	34	63	66	80	80	90	82	92	92
Collaboration	38	77	79	93	92	100	100	100	100	100	100	100

Note: The unit of analysis changed from hospitals (n=27) to DHBs (n=20) beginning in 2013. The 2012 scores include independent scores (n=13 hospitals) and self-audit scores (n=14 hospitals); the 2013 and 2014 scores include self audit (n=16) and independent (n=4) audit scores; 2015, 2016 and 2017 scores are all (n=20) from self audits.

APPENDIX H (B) INTIMATE PARTNER VIOLENCE DELPHI ACHIEVEMENT OF TARGET SCORE 2004 TO 2017

ACHIEVING TARGET SCORE ≥ 70								≥ 80			
n (%)	2004	2005	2007	2008	2009	2011	2012	2013	2014	2016	2017
Overall Score	1 (4%)	2 (8%)	5 (19%)	13 (48%	15 (56%)	25 (93%)	27 (100%)	19 (95%)	20 (100%)	19 (95%)	19 (95%)
Domain Score											
Policies & Procedures	1 (4%)	2 (8%)	7 (26%)	11 (41%)	16 (59%)	20 (74%)	24 (89%)	18 (90%)	19 (95%)	19 (95%)	19 (95%)
Physical Environment	0 (0%)	1 (4%)	4 (15%)	16 (59%)	16 (59%)	23 (85%)	25 (93%)	18 (90%)	19 (95%)	19 (95%)	16 (80%)
Institutional Culture	2 (8%)	5 (20%)	8 (30%)	15 (56%)	16 (59%)	23 (85%)	25 (93%)	18 (90%)	19 (95%)	18 (90%)	18 (90%)
Training of Providers	1 (4%)	5 (20%)	8 (30%)	15 (56%)	18 (67%)	26 (96%)	26 (96%)	19 (95%)	20 (100%)	17 (85%)	18 (90%)
Screening & Safety Assessment	1 (4%)	5 (20%)	8 (30%)	15 (56%)	18 (67%)	26 (96%)	26 (96%)	19 (95%)	20 (100%)	19 (95%)	20 (100%)
Documentation	0 (0%)	0 (0%)	2 (7%)	12 (44%)	14 (52%)	22 (82%)	24 (89%)	18 (90%)	18 (90%)	16 (80%)	19 (95%)
Intervention Services	4 (16%)	6 (24%)	9 (33%)	11 (41%)	17 (63%)	24 (89%)	27 (100%)	20 (100%)	20 (100%)	18 (90%)	20 (100%)
Evaluation Activities	1 (4%)	1 (4%)	4 (15%)	6 (22%)	11 (41%)	13 (48%)	23 (85%)	14 (70%)	15 (75%)	15 (75%)	15 (75%)
Collaboration	1 (4%)	15 (60%)	19 (70%)	23 (85%)	25 (93%)	27 (100%)	27 (100%)	20 (100%)	20 (100%)	20 (100%_	20 (100%)

Note: The unit of analysis changed from hospitals (n=27) to DHBs (n=20) for the 2013 audit. The selected benchmark score was raised from 70 to 80 beginning in 2015. The 2012 follow-up scores include independent scores (n=13 hospitals) and self-audit scores (n=14 hospitals). The 2013 and 2014 follow-up scores include self audit scores (n=16) and independent audit scores (n=4). The 2015, 2016 and 2017 scores are all (n=20) self audit scores.

APPENDIX I: INTIMATE PARTNER VIOLENCE DELPHI ITEM ANALYSIS

	"YES" responses (highlighted cells < 80%)	2015 FU DHBs (%)	2016 FU DHBs (%)	2017 FU DHBs (%)
CATEGORY 1. POLICIES AND PROCEDURES				
1.1	Are there official, written hospital policies regarding the assessment and treatment of victims of partner abuse? If yes, do policies:	20 (100%)	20 (100%)	20 (100%)
	a) define partner abuse?	20 (100%)	20 (100%)	20 (100%)
	b) mandate training on partner abuse for any staff?	19 (95%)	20 (100%)	20 (100%)
	c) advocate universal screening for women anywhere in the hospital?	20 (100%)	20 (100%)	20 (100%)
	d) define who is responsible for screening?	20 (100%)	20 (100%)	20 (100%)
	e) address documentation?	19 (95%)	20 (100%)	20 (100%)
	f) address referral of victims?	20 (100%)	20 (100%)	20 (100%)
	g) address legal reporting requirements?	20 (100%)	19 (95%)	20 (100%)
	h) address the responsibilities to, and needs of, Māori?	20 (100%)	19 (95%)	19 (95%)
	i) address the needs of other (non-Māori/non-Pakeha) cultural and/or ethnic groups?	20 (100%)	20 (100%)	20 (100%)
	j) address the needs of LGBT clients?	18 (90%)	18 (90%)	20 (100%)
1.2	Is there evidence of a hospital-based partner abuse working group? If yes, does the group:	19 (95%)	19 (95%)	19 (95%)
	a) meet at least every month?	8 (40%)	9 (45%)	8 (40%)
	b) include representative(s) from more than two departments?	20 (100%)	19 (95%)	19 (95%)
	c) include representative(s) from the security department?	16 (80%)	14 (70%)	12 (60%)
	d) include physician(s) from the medical staff?	17 (85%)	17 (85%)	15 (75%)
	e) include representative(s) from a partner abuse advocacy organization (e.g. Women's Refuge)?	19 (95%)	19 (95%)	18 (90%)
	f) include representative(s) from hospital administration?	20 (100%)	19 (95%)	19 (95%)
	g) include Māori representative(s)?	20 (100%)	19 (95%)	19 (95%)
1.3	Does the hospital provide direct financial support for the partner abuse programme (beyond VIP funding)?	20 (100%)	20 (100%)	19 (95%)
1.3a	Is funding set aside specifically for Māori programmes and initiatives?	11 (55%)	12 (60%)	11 (55%)
1.4	Is there a mandatory universal screening policy in place?	20 (100%)	20 (100%)	20 (100%)

	"YES" responses (highlighted cells < 80%)	2015 FU DHBs (%)	2016 FU DHBs (%)	2017 FU DHBs (%)
1.5	Are there quality assurance procedures in place to ensure partner abuse screening?	20 (100%)	20 (100%)	20 (100%)
	a) regular chart audits to assess screening?	20 (100%)	20 (100%)	20 (100%)
	b) positive reinforcers to promote screening?	19 (95%)	19 (95%)	19 (95%)
	c) is there regular supervision?	18 (90%)	17(85%)	19 (95%)
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?	20 (100%)	18 (90%)	18 (90%)
	b) procedures that include name/phone block for victims admitted to hospital?	18 (90%)	18 (90%)	18 (90%)
	c) procedures that include provisions for safe transport from the hospital to shelter?	19 (95%)	18 (90%)	20 (100%)
	d) do these procedures take into account the needs of Māori?	20 (100%)	20 (100%)	12 (60%)
1.7	Is there an identifiable partner abuse coordinator at the hospital? If yes is it a: (choose one)	20 (100%)	20 (100%)	12 (60%)
	a) part time position or included with other responsibilities?	8 (40%)	6 (30%)	8 (40%)
	b) full-time position with no other responsibilities?	12 (60%)	14 (70%)	12 (60%)
CATEGORY 2. PHYSICAL ENVIRONMENT				
2.1	In how many locations are posters/brochures related to partner abuse on display in the hospital? (up to 35)			
	11-20	1 (5%)	1 (5%)	2 (10%)
	21-35	19 (95%)	19 (95%)	18 (90%)
	In how many locations are there Māori images related to partner abuse on display? (up to 17):			
	1-10	1 (5%)	1 (5%)	1 (5%)
	11-17	19 (95%)	19 (95%)	19 (95%)
2.2	In how many locations is there referral information related to partner abuse services on display in the hospital? (Can be included on the posters/brochure noted above) (up to 35):			
	11-20	2 (10%)	3 (15%)	3 (15%)
	21-35	18 (90%)	17 (85%)	17 (85%)
	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	2 (10%)	3 (15%)	2 (10%)
	11-17	18 (90%)	17 (85%)	18 (90%)
	In how many locations is there referral information re non- Māori non-Pakeha on public display? (up to 17)			
	0-6	2 (10%)	1 (5%)	3 (15%)
	7-17	18 (90%)	19 (95%)	17 (85%)

	"YES" responses (highlighted cells < 80%)	2015 FU DHBs (%)	2016 FU DHBs (%)	2017 FU DHBs (%)
2.3	Does the hospital provide temporary (<24 hours) safe shelter for victims of partner abuse who cannot go home or cannot be placed in a community-based shelter? If yes:	20 (100%)	20 (100%)	20 (100%)
	a) Does the design and use of the safe shelter support Māori cultural beliefs and practices?	18 (90%)	19 (95%)	19 (95%)
CATEGORY 3. INSTITUTIONAL CULTURE				
3.1	In the last 3 years, has there been a formal (written) assessment of the hospital staff's knowledge and attitude about partner abuse? If yes, which groups have been assessed?			
	a) nursing staff	18 (90%)	19 (95%)	19 (95%)
	b) medical staff	15 (75%)	16 (80%)	18 (90%)
	c) administration	12 (60%)	15 (75%)	16 (80%)
	d) other staff/employees	17 (85%)	18 (90%)	18 (90%)
	If yes, did the assessment address staff knowledge and attitude about Māori and partner abuse?	15 (75%)	15 (75%)	16 (80%)
3.2	How long has the hospital's partner abuse programme been in existence?			
	1-24 months	0 (0%)	0 (0%)	0 (0%)
	24-48 months	0 (0%)	0 (0%)	0 (0%)
	>48 months	20 (100%)	20 (100%)	20 (100%)
3.3	Does the hospital address the following in responding to employees experiencing partner abuse?			
	a) Is there a hospital policy covering the topic of partner abuse in the workplace?	18 (90%)	19 (95%)	19 (95%)
	b) Does the Employee Assistance programme (or equivalent) maintain specific policies and procedures for dealing with employees experiencing partner abuse?	16 (80%)	18 (90%)	18 (90%)
	c) Is the topic of partner abuse among employees covered in the hospital training sessions and/or orientation?	20 (100%)	20 (100%)	20 (100%)
3.4	Does the hospital's partner abuse programme address cultural competency issues? If yes:			
	a) Does the hospital's policy specifically recommend universal screening regardless of the patient's cultural background?	20 (100%)	20 (100%)	20 (100%)
	b) Are cultural issues discussed in the hospital's partner abuse training programme?	20 (100%)	20 (100%0	20 (100%)
	c) Are translators/interpreters available for working with victims if English is not the victim's first language?	20 (100%)	19 (95%)	20 (100%)
	d) Are referral information and brochures related to partner abuse available in languages other than English?	20 (100%)	20 (100%)	20 (100%)
3.5	Does the hospital participate in preventive outreach and public education activities on the topic of partner abuse? If yes, is there documentation of: (a or b and answer c)	19 (95%)	20 (100%)	18 (90%)
	a) 1 programme in the last 12 months?	1 (5%)	1(5%)	1 (5%)
	b) >1 programme in the last 12 months?	19 (95%)	19 (95%)	18 (90%)
	c) Does the hospital collaborate with Māori community organizations and providers to deliver preventive outreach and public education activities?	19 (95%)	18 (90%)	17 (85%)

	"YES" responses (yellow highlighted cells < 80%)	2015 FU DHBs (%)	2016 FU DHBs (%)	2017 FUDHBs (%)
CATEGORY 4. TRAINING OF PROVIDERS				
4.1	Has a formal training plan been developed for the institution? If yes:	19 (95%)	18 (90%)	19 (95%)
	a) Does the plan include the provision of regular, ongoing education for clinical staff?	20 (100%)	18 (90%)	19 (95%)
	b) Does the plan include the provision of regular, ongoing education for non-clinical staff?	18 (90%)	17 (85%)	17 (85%)
4.2	During the past 12 months, has the hospital provided training on partner abuse:			
	a) as part of the mandatory orientation for new staff?	20 (100%)	20 (100%)	20 (100%)
	b) to members of the clinical staff via colloquia or other sessions?	20 (100%)	19 (95%)	20 (100%)
4.3	Does the hospital's training/education on partner abuse include information about?			
	a) definitions of partner abuse?	20 (100%)	20 (100%)	20 (100%)
	b) dynamics of partner abuse?	20 (100%)	20 (100%)	20 (100%)
	c) epidemiology?	20 (100%)	20 (100%)	20 (100%)
	d) health consequences?	20 (100%)	20 (100%)	20 (100%)
	e) strategies for screening?	20 (100%)	20 (100%)	20 (100%)
	f) risk assessment?	20 (100%)	20 (100%)	20 (100%)
	g) documentation?	20 (100%)	20 (100%)	20 (100%)
	h) intervention?	20 (100%)	20 (100%)	20 (100%)
	i) safety planning?	20 (100%)	20 (100%)	20 (100%)
	j) community resources?	20 (100%)	20 (100%)	20 (100%)
	k) reporting requirements?	20 (100%)	20 (100%)	20 (100%)
	l) legal issues?	20 (100%)	20 (100%)	20 (100%)
	m) confidentiality?	20 (100%)	20 (100%)	20 (100%)
	n) cultural competency?	20 (100%)	20 (100%)	20 (100%)
	o) clinical signs/symptoms?	20 (100%)	20 (100%)	20 (100%)
	p) Māori models of health?	20 (100%)	19 (95%)	20 (100%)
	q) risk assessment for children of victims?	20 (100%)	20 (100%)	20 (100%)
	r) social, cultural, historic, and economic context in which Māori family violence occurs?	18 (90%)	20 (100%)	20 (100%)
	s) Te Tiriti o Waitangi?	20 (100%)	20 (100%)	20 (100%)
	t) Māori service providers and community resources?	20 (100%)	19 (95%)	19 (95%)
	u) service providers and community resources for ethnic and cultural groups other than Pakeha and Māori?	20 (100%)	19 (95%)	19 (95%)
	v) partner abuse in same-sex relationships?	20 (100%)	19 (95%)	19 (95%)
	w) service providers and community resources for victims of partner abuse who are in same-sex relationships?	20 (100%)	19 (95%)	19 (95%)

	"YES" responses (yellow highlighted cells < 80%)	2015 FU DHBs (%)	2016 FU DHBs (%)	2017 FU DHBs (%)
4.4	Is the partner abuse training provided by: (choose one a-c and answer d-e)			
	a) a single individual?	0 (0%)	0 (0%)	0 (0%)
	b) a team of hospital employees only?	0 (0%)	0 (0%)	0 (0%)
	c) a team, including community expert(s)?	20 (100%)	19 (95%)	20 (100%)
	If provided by a team, does it include:			
	d) a Māori representative?	19 (95%)	18 (90%)	18 (90%)
	e) a representative(s) of other ethnic/cultural groups?	15 (75%)	14 (70%)	14 (70%)
CATEGORY 5. SCREENING AND SAFETY ASSESSMENT				
5.1	Does the hospital use a standardized instrument, with at least 3 questions, to screen patients for partner abuse? If	20 (100%)	20 (100%)	20 (100%)
	a) included, as a separate form, in the clinical record?	0 (0%)	1 (5%)	0 (0%)
	b) incorporated as questions in the clinical record for all charts in ED or other out-patient area?	0 (0%)	1 (5%)	2 (10%)
	c) incorporated as questions in the clinical record for all charts in two or more out-patient areas?	8 (40%)	8 (40%)	8 (40%)
	d) incorporated as questions in clinical record for all charts in out-patient and in-patient areas?	12 (60%)	10 (50%)	10 (50%)
5.2	What percentage of eligible patients have documentation of partner abuse screening (based upon random sample of charts in any clinical area)?			
	Not done or not applicable	1 (5%)	0 (0%)	0 (0%)
	0% - 10%	0 (0%)	1 (5%)	0 (0%)
	11% - 25%	0 (0%)	0 (0%)	0 (0%)
	26% - 50%	5 (25%)	3 (15%)	6 (30%)
	51% - 75%	10 (50%)	10 (50%)	8 (40%)
	76% - 100%	4 (20%)	6 (30%)	6 (30%)
5.3	Is a standardized safety assessment performed and discussed with victims who screen positive for partner abuse? If yes, does this:	20 (100%)	20 (100%)	20 (100%)
	a) also assess the safety of any children in the victim's care?	20 (100%)	20 (100%)	20 (100%)
CATEGORY 6. DOCUMENTATION				
6.1	Does the hospital use a standardized documentation instrument to record known or suspected cases of partner abuse? If yes, does the form include:	20 (100%)	20 (100%)	20 (100%)
	a) information on the results of partner abuse screening?	20 (100%)	20 (100%)	20 (100%)
	b) the victim's description of current and/or past abuse?	20 (100%)	20 (100%)	20 (100%)
	c) the name of the alleged perpetrator and relationship to the victim?	20 (100%)	20 (100%)	20 (100%)
	d) a body map to document injuries?	19 (95%)	19 (95%)	19 (95%)
	e) information documenting the referrals provided to the victim?	20 (100%)	20 (100%)	20 (100%)
	f) in the case of Māori, information documenting whether the individual was offered a Māori advocate?	20 (100%)	19 (95%)	20 (100%)

	"YES" responses (highlighted cells < 80%)	2015 FU DHBs (%)	2016 FU DHBs (%)	2017 FU DHBs (%)
6.2	Is forensic photography incorporated in the documentation procedure? If yes:			
	a) Is a fully operational camera with adequate film available in the treatment area?	20 (100%)	19 (95%)	19 (95%)
	b) Do hospital staff receive on-going training on the use of the camera?	15 (75%)	17 (85%)	16 (80%)
	c) Do hospital staff routinely offer to photograph all abused patients with injuries?	13 (65%)	13 (65%)	14 (100%)
	d) Is a specific, unique consent-to-photograph form obtained prior to photographing any injuries?	15 (75%)	15 (75%)	18 (90%)
	e) Do medical or nursing staff (not social work or a partner abuse advocate) photograph all injuries for medical documentation purposes, even if police obtain their own photographs for evidence purposes?	17 (85%)	14 (70%)	16 (80%)
CATEGORY 7. INTERVENTION SERVICES				
7.1	Is there a standard intervention checklist for staff to use/refer to when victims are identified?	20 (100%)	20 (100%)	20 (100%)
7.2	Are on-site victim advocacy services provided? If yes, choose one a-b and answer c-d):	20 (100%)	20 (100%)	18 (90%)
	a) A trained victim advocate provides services during certain hours.	4 (20%)	4 (20%)	2 (10%)
	b) A trained victim advocate provides service at all times.	16 (80%)	16 (80%)	18 (90%)
	c) is a Māori advocate available on-site for Māori victims?	19 (95%)	19 (95%)	19 (95%)
	d) is an advocate(s) of ethnic and cultural background other than Pakeha and Māori available onsite?	18 (90%)	18 (90%)	20 (100%)
7.3	Are mental health/psychological assessments performed within the context of the programme? If yes, are they:	20 (100%)	20 (100%)	20 (100%)
	a) available, when indicated?	9 (45%)	9 (45%)	7 (35%)
	b) performed routinely?	11 (55%)	11 (55%)	13 (65%)
7.4	Is transportation provided for victims, if needed?	20 (100%)	19 (95%)	19 (95%)
7.5	Does the hospital partner abuse programme include follow-up contact and counselling with victims after the initial assessment?	20 (100%)	20 (100%)	20 (100%)
7.6	Does the hospital partner abuse programme offer and provide on-site legal options counselling for victims?	20 (100%)	20 (100%)	20 (100%)
7.7	Does the hospital partner abuse programme offer and provide partner abuse services for the children of victims?	20 (100%)	20 (100%)	20 (100%)
7.8	Is there evidence of coordination between the hospital partner abuse programme and sexual assault, mental health and substance abuse screening and treatment?	20 (100%)	19 (95%)	20 (100%)
CATEGORY 8. EVALUATION ACTIVITIES				
8.1	Are any formal evaluation procedures in place to monitor the quality of the partner abuse programme? If yes:	19 (95%)	19 (95%)	19 (95%)
	a) Do evaluation activities include periodic monitoring of charts to audit for partner abuse screening?	20 (100%)	20 (100%)	20 (100%)
	b) Do evaluation activities include peer-to-peer case reviews around partner abuse?	18 (90%)	18 (90%)	19 (95%)
8.2	Do health care providers receive standardized feedback on their performance and on patients?	19 (95%)	19 (95%)	20 (100%)
8.3	Is there any measurement of client satisfaction and/or community satisfaction with the partner abuse programme?	15 (75%)	14 (70%)	14 (70%)
8.4	Is a quality framework (such as Whānau Ora) used to evaluate whether services are effective for Māori?	11 (55%)	14 (70%)	12 (60%)

	"YES" responses (highlighted cells < 80%)	2015 FU DHBs (%)	2016 FU DHBs (%)	2017 FU DHBs (%)
CATEGORY 9. COLLABORATION				
9.1	Does the hospital collaborate with local partner abuse programmes? If yes,	20 (100%)	20 (100%)	20 (100%)
	a i) collaboration with training?	20 (100%)	20 (100%)	20 (100%)
	ii) collaboration on policy and procedure development?	20 (100%)	19 (95%)	19 (95%)
	iii) collaboration on partner abuse working group?	20 (100%)	20 (100%)	19 (95%)
	iv) collaboration on site service provision?	20 (100%)	20 (100%)	20 (100%)
	b) is collaboration with			
	i) Māori provider(s) or representative(s)?	20 (100%	20 (100%)	20 (100%)
	ii) Provider(s) or representative(s) for ethnic or cultural groups other than Pakeha or Māori?	18 (90%)	18 (90%)	18 (90%)
9.2	Does the hospital collaborate with local police and courts in conjunction with their partner abuse programme? If yes:	20 (100%)	20 (100%)	20 (100%)
	a) collaboration with training?	20 (100%)	20 (100%)	20 (100%)
	b) collaboration on policy and procedure development?	20 (100%)	19 (95%)	19 (95%)
	c) collaboration on partner abuse working group?	20 (100%)	19 (95%)	17 (85%)
9.3	Is there collaboration with the partner abuse programme of other health care facilities? If yes, which types of collaboration apply:	20 (100%)	20 (100%)	20 (100%)
	a) within the same health care system?	20 (100%)	20 (100%)	20 (100%)
	If yes, with a Māori health unit?	18 (90%)	18 (90%)	18 (90%)
	b) with other systems in the region?	20 (100%)	20 (100%)	20 (100%)
	If yes, with a Māori health provider?	18 (90%)	18 (90%)	18 (90%)

APPENDIX J (A) CHILD ABUSE AND NEGLECT DELPHI SUMMARY SCORES 2004 TO 2017

Median Scores	2004	2005	2007	2008	2009	2011	2012	2013	2014	2015	2016	2017
Overall Score	37	51	60	75	81	87	91	92	93	93	94	95
Domain Scores												
Policies and Procedures	43	50	60	81	84	92	95	95	96	94	93	95
Safety and Security	-	-	-	77	72	82	90	92	96	100	99	99
Collaboration	47	71	85	83	91	94	97	98	100	100	100	100
Institutional Culture	42	43	57	80	82	86	90	94	96	96	96	96
Training of Providers	40	49	67	93	96	98	100	100	100	99	98	98
Intervention Services	65	70	73	82	84	89	92	89	89	91	93	94
Documentation	19	29	58	84	83	87	93	96	97	100	95	100
Evaluation Activities	35	37	37	30	59	72	76	73	80	82	82	82
Physical Environment	23	28	35.6	68	91	100	100	100	100	91	100	100

Note: The unit of analysis changed from hospitals (n=27) to DHBs (n=20) for the 2013 audit. The selected benchmark score was raised from 70 to 80 beginning in 2015. The 2012 follow-up scores include independent scores (n=13 hospitals) and self-audit scores (n=14 hospitals). The 2013 and 2014 follow-up scores include self audit scores (n=16) and independent audit scores (n=4). The 2015, 2016 and 2017 scores are all (n=20) self audit scores. The CAN audit tool was revised for the 2008 audit.

APPENDIX J (B) CHILD ABUSE AND NEGLECT DELPHI ACHIEVEMENT OF TARGET SCORE 2004 TO 2017

Achieving Target Score ≥ 70										≥ 80		
n (%)	**2004**	**2005**	**2007**	**2008**	**2009**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
Overall Score	2	3	4	17	21	25	27	19	20	20	19	19
	(8%)	(12%)	(15%)	(65%)	(78%)	(93%)	(100%)	(95%)	(100%)	(95%)	(95%)	(95%)
Domain Scores												
Policies and Procedures	3 (12%)	5 (20%)	8 (29%)	23 (89%)	19 (70%)	26 (96%)	27 (100%)	20 (100%)	20 (100%)	20 (100%)	19 (95%)	19 (95%)
Safety and Security	-	-	-	17 (65%)	17 (63%)	23 (85%)	27 (100%)	19 (95%)	20 (100%)	20 (100%)	20 (100%)	19 (95%)
Collaboration	5 (20%)	15 (60%)	20 (74%)	21 (81%)	25 (93%)	26 (96%)	27 (100%)	20 (100%)	20 (100%)	20 (100%)	20 (100%)	20 (100%)
Institutional Culture	3 (12%)	5 20%	6 22%	18 69%	20 74%	25 93%	27 (100%)	20 (100%)	20 (100%)	19 (95%)	19 (95%)	19 (95%)
Training of Providers	2 (8%)	9 (36%)	14 (52%)	19 (73%)	22 (82%)	26 (96%)	27 (100%)	20 (100%)	20 (100%)	20 (100%)	19 (95%)	19 (95%)
Intervention Services	12 (48%)	13 (52%)	15 (56%)	21 (81%)	22 (82%)	27 (100%)	27 (100%)	20 (100%)	20 (100%)	20 (100%)	20 (100%)	20 (100%)
Documentation	5 (20%)	5 (20%)	8 (29%)	22 (85%)	19 70%)	22 (82%)	24 (89%)	19 (95%)	19 (95%)	18 (90%)	18 (90%)	18 (90%)
Evaluation Activities	1 (4%)	1 (4%)	5 (20%)	3 (12%)	7 (26%)	14 (52%)	18 (67%)	11 (55%)	15 (75%)	13 (65%)	12 (60%)	12 (60%)
Physical Environments	1 (4%)	2 (5%)	2 (7%)	12 (46%)	26 (96%)	27 (100%)	27 (100%)	19 (95%)	20 (100%)	18 (18%)	16 (80%)	16 (80%)

Note: The unit of analysis changed from hospitals (n=27) to DHBs (n=20) for the 2013 audit. The selected benchmark score was raised from 70 to 80 beginning in 2015. The 2012 follow-up scores include independent scores (n=13 hospitals) and self-audit scores (n=14 hospitals). The 2013 and 2014 follow-up scores include self audit scores (n=16) and independent audit scores (n=4). The 2015, 2016 and 2017 scores are all (n=20) self audit scores. The CAN audit tool was revised for the 2008 audit.

	"YES" responses (highlighted cells < 80%)	2015 FU DHBs (%)	2016 FU DHBs (%)	2017 FU DHBs (%)
CATEGORY 1. POLICIES AND PROCEDURES				
1.1	Are there official, written DHB policies regarding the clinical assessment, appropriate questioning, and treatment of suspected abused and neglected children? If so, do the policies:	20 (100%)	20 (100%)	20 (100%)
	a) Define child abuse and neglect?	20 (100%)	20 (100%)	20 (100%)
	b) Mandate training on child abuse and neglect for staff?	20 (100%)	20 (100%)	20 (100%)
	c) Outline age-appropriate protocols for risk assessment?	19 (95%)	18 (90%)	20 (100%)
	d) Define who is responsible for risk assessment?	20 (100%	19 (95%)	20 (100%)
	e) Address the issue of contamination during interviewing?	20 (100%)	19 (95%)	18 (90%)
	f) Address documentation?	20 (100%)	20 (100%)	20 (100%)
	g) Address referrals for children and their families?	20 (100%)	20 (100%)	20 (100%)
	h) Address child protection reporting requirements?	20 (100%)	20 (100%)	20 (100%)
	i) Address the responsibilities to, and needs of, Māori?	20 (100%)	19 (95%)	19 (95%)
	j) Address other cultural and/or ethnic groups?	20 (100%)	20 (100%)	20 (100%)
1.2	Who is consulted regarding child protection policies and procedures?			
	Māori and Pacific?	20 (100%)	20 (100%)	20 (100%)
	CYF?	20 (100%)	20 (100%)	20 (100%)
	Police?	20 (100%)	20 (100%)	20 (100%)
	Child abuse and neglect programme and Violence Intervention Programme staff?	20 (100%)	20 (100%)	20 (100%)
	Plus, Other Agencies: such as Refuge; National Network of Stopping Violence Services (NNSVS); Office of the Children's Commissioner (OCC); Community Alcohol & Drug Service (CADS)	20 (100%)	19 (95%)	19 (95%)
1.3	Is there evidence of a DHB-based child abuse and neglect steering group? If yes, does the:			
	a) Steering group meet at least every three (3) months?	15 (75%)	17 (85%)	18 (90%)
	b) Include representatives from more than two departments?	17 (85%)	19 (95%)	19 (95%)

	"YES" responses (highlighted cells < 80%)	2015 FU DHBs (%)	2016 FU DHBs (%)	2017 FU DHBs (%)
1.4	Does the DHB provide direct financial support for the child abuse and neglect programme (beyond VIP funding)?	20 (100%)	20 (100%)	19 (95%)
	a) Is funding set aside specifically for Māori programmes and initiatives?	13 (65%)	12 (60%)	12 (60%)
1.5	Is there a policy for identifying signs and symptoms of child abuse and neglect and for identifying children at high risk? a) in both inpatient and outpatient areas?	20 (100%)	20 (100%)	20 (100%)
1.6	Are there procedures for security measures to be taken when suspected cases of child abuse and neglect are identified and the child is perceived to be at immediate risk? If yes, are the procedures:			
	a) written?	20 (100%	20 (100%)	20 (100%)
	b) include name/phone block?	19 (95%)	18 (90%)	19 (95%)
	c) provide for safe transportation?	20 (100%)	18 (90%)	20 (100%)
	d) account for the needs of Māori?	19 (100%)	19 (95%)	19 (95%)
1.7	Is there an identifiable child protection coordinator at the DHB? If yes, is the coordinator position (choose one):	20 (100%)	20 (100%)	20 (100%)
	a) part-time <0.5 FTE	2 (10%)	3 (15%)	2 (10%)
	b) part-time ≥0.5 FTE?	7 (35%)	5 (25%)	5 (25%)
	c) full-time?	11 (55%)	12 (60%)	13 (65%)
1.8	Are there policies that outline the minimum expectation for all staff:			
	a) to attend mandatory training?	20 (20%)	20 (100%)	20 (100%)
	b) to identification and referral children at risk?	20 (100%)	20 (100%)	20 (100%)
	c) to reporting child protection concerns?	20 (100%)	20 (100%)	20 (100%)
1.9	Do the child abuse and neglect policies and procedures indicate collaboration with government agencies and other relevant groups, such as the Police, CYF, refuge, and NNSVS ('men's programme provider')?			
	a) government agencies?	20 (100%)	19 (95%)	20 (100%)
	b) community groups?	20 (100%)	19 (95%)	20 (100%)
1.10	Are the DHB policies and procedures easily accessible and user-friendly? If yes, are			
	a) they available on the DHB intranet?	19 (95%)	19 (95%)	19 (95%)
	b) there supporting and reference documents appended to the appropriate policies and procedures?	18 (90%)	18 (90%)	19 (95%)
	c) there translation materials to facilitate the application of policy and procedures, such as flowcharts and algorithms?	19 (95%)	18 (90%)	19 (95%)
1.11	Are the DHB policies and procedures cross-referenced to other forms of family violence, such as partner abuse and elder abuse?	20 (100%)	20 (100%)	20 (100%)

	"YES" responses (highlighted cells < 80%)	2015 FU DHBs (%)	2016 FU DHBs (%)	2017 FU DHBs (%)
CATEGORY 2. SAFETY & SECURITY				
2.1	Does the DHB have a policy in place that all children are assessed when signs and symptoms are suggestive of abuse and/or neglect?	20 (100%)	20 (100%)	20 (100%)
2.2	Does the DHB have a protocol for collaborative safety planning for children at high risk?			
	a) are safety plans available or used for children identified at risk? Which types of collaboration apply:	20 (100%)	20 (100%)	20 (100%)
	b) within the DHB?	20 (100%)	20 (100%)	20 (100%)
	c) with other groups and agencies in the region?	20 (100%)	20 (100%)	20 (100%)
	d) with Māori and Pacific health providers?	20 (100%)	20 (100%)	20 (100%)
	e) with other relevant ethnic/cultural groups?	19 (95%)	18 (90%)	17 (85%)
	f) with the primary health sector?	20 (100%)	17 (85%)	20 (100%)
2.3	Does the DHB have a protocol to promote the safety of children identified at risk of abuse or neglect?			
	a) within the DHB?	20 (100%)	20 (100%)	20 (100%)
	b) with relevant primary health care providers as part of discharge planning?	20 (100%)	20 (100%)	20 (100%)
	c) by accessing necessary support services for the child and family to promote ongoing safety of the child?	20 (100%)	20 (100%)	20 (100%)
2.4	Do inpatient facilities have a security plan where people at risk of perpetrating abuse, or who have a protection order against them, can be denied entry?	20 (100%)	20 (100%)	20 (100%)
2.5	Do the DHB services have an alert system or a central database recording any concerns about children at risk of abuse and neglect in place?			
	b) a local alert system in acute care setting	19 (95%)	19 (95%)	19 (95%)
	c) a local alert system in community setting, including PHO	15 (75%)	13 (65%)	13 (65%)
	d) a process for notification of alert placements to relevant providers	18 (90%)	16 (80%)	17 (85%)
	e) participation in a national alert system (108 Mo. note 8 NCPAS approved + 3 self-reporting that in process)	18 (90%)	20 (100%)	20 (100%)
	f) clear criteria for identifying levels of risk, and process that guides the use of the alert system	19 (95%)	20 (100%)	20 (100%)
2.6	Is there evidence in protocols of processes to assess or refer to CYF and/or other appropriate agencies all children living in the house when child abuse and neglect or partner violence has been identified?			
	a) process that includes the safety of other children in the home are considered?	20 (100%)	20 (100%)	20 (100%)
	b) process for notifying CYF and/or other agencies?	20 (100%)	20 (100%)	20 (100%)
	c) referral form that requires the documentation of the risk assessed for these children?	20 (100%)	20 (100%)	20 (100%)

	"YES" responses (highlighted cells < 80%)	2015 FU DHBs (%)	2016 FU DHBs (%)	2017 FU DHBs (%)
CATEGORY 3. COLLABORATION				
3.1	Does the DHB collaborate with CYF / Oranga Tamariki and NGO child advocacy and protection?	20 (100%)	20 (100%)	20 (100%)
	a) which types of collaboration apply:			
	i) collaboration with training?	20 (100%)	20 (100%)	20 (100%)
	ii) collaboration on policy and procedure development?	20 (100%)	20 (100%)	20 (100%)
	iii) collaboration on child abuse and neglect task force?	20 (100%)	19 (95%)	20 (100%)
	iv) collaboration on site service provision?	20 (100%)	20 (100%)	20 (100%)
	v) collaboration is two-way?	20 (100%)	20 (100%)	20 (100%)
	b) is collaboration with:			
	i) CYF/ Oranga Tamariki?	20 (100%)	20 (100%)	20 (100%)
	ii) NGOs and other agencies such as Women's Refuge?	19 (95%)	19 (95%)	20 (100%)
	iii) Māori provider(s) or representative(s)?	20 (100%)	20 (100%)	20 (100%)
	iv) Provider(s) or representative(s) for ethnic or cultural groups other than Pakeha or Māori?	19 (95%)	20 (100%)	20 (100%)
	c) services, departments and between relevant staff within the DHB evident?	20 (100%)	20 (100%)	20 (100%)
3.2	Does the DHB collaborate with police and prosecution agencies in conjunction with their child abuse and neglect programme? If yes, which types of collaboration apply:	20 (100%)	20 (100%)	20 (100%)
	a) collaboration with training?	20 (100%)	19 (95%)	20 (100%)
	b) collaboration on policy and procedure development?	20 (100%)	20 (100%)	20 (100%)
	c) collaboration on child abuse and neglect task force?	18 (90%)	19 (95%)	20 (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:	20 (100%)	20 (100%)	20 (100%)
	a) within the DHB?	20 (100%)	20 (100%)	20 (100%)
	b) with a Māori unit?	20 (100%)	20 (100%)	20 (100%)
	c) with other groups and agencies in the region?	20 (100%)	20 (100%)	20 (100%)
	d) with a Māori health provider?	20 (100%)	20 (100%)	20 (100%)
	e) with the primary health care sector?	19 (95%)	20 (100%)	20 (100%)
	f) with national network of child protection and family violence coordinators?	20 (100%)	20 (100%)	20 (100%)

	"YES" responses (highlighted cells < 80%)	2015 FU DHBs (%)	2016 FU DHBs (%)	2017 FU DHBs (%)
3.4	Do relevant staff have membership on, or attend:			
	a) the interdisciplinary child protection team?	20 (100%)	20 (100%)	20 (100%)
	b) Child abuse team meetings?	19 (95%)	19 (95%)	20 (100%)
	c) Sexual abuse team meetings?	16 (80%)	17 (85%)	17 (85%)
	d) CYF/Oranga Tamariki Care and Protection Resource Panel?	15 (75%)	17 (85%)	17 (85%)
	e) National Network of Family Violence Intervention Coordinators?	19 (95%)	19 (95%)	19 (95%)
3.5	Does the DHB have a Memorandum of Understanding that enables the sharing of details of children at risk for entry on their database with the Police and/or CYF/Oranga Tamariki?			
	a) CYF/Oranga Tamariki?	20 (100%)	20 (100%)	20 (100%)
	b) the Police?	20 (100%)	20 (100%)	20 (100%)
3.6	Does the DHB have a Memorandum of Understanding or service agreement that enables timely medical examinations to support:			
	a) CYF/Oranga Tamariki?	20 (100%)	20 (100%)	20 (100%)
	b) Police?	20 (100%)	20 (100%)	20 (100%)
	c) DSAC?	18 (90%)	19 (95%)	20 (100%)
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?	19 (95%)	16 (80%)	18 (90%)
	b) child protection is in the DHB Annual Plan?	20 (100%)	19 (95%)	20 (100%)
	c) the child protection programme is adequately resourced, including dedicated programme staff?	18 (90%)	16 (80%)	17 (85%)
	d) a working group of skilled and trained people who operationalises policies and procedures, in addition to the child protection coordinator?	20 (100%)	20 (100%)	20 (100%)
	e) attendance at training as a key performance indicator (KPI) for staff?	15 (75%)	15 (75%)	15 (75%)
	f) roles of those in the child abuse and neglect working team are included in position descriptions?	18 (90%)	17 (85%)	17 (85%)
	g) DHB representation on the CYF/Oranga Tamariki Care and Protection Resource Panel?	17 (85%)	19 (95%)	18 (90%)
	h) the Child Protection Coordinator is supported to attend the VIP Coordinator Meetings?	19 (95%)	20 (100%)	20 (100%)

	"YES" responses (highlighted cells < 80%)	2015 FU DHBs (%)	2016 FU DHBs (%)	2017 FU DHBs (%)
4.2	In the last 3 years, has there been a formal (written) assessment of the DHB staff's knowledge and attitude about child abuse and neglect?			
	a) nursing staff	17 (85%)	16 (80%)	19 (95%)
	b) medical staff	14 (70%)	16 (80%)	19 (95%)
	c) administration	12 (60%)	13 (65%)	16 (80%)
	d) other staff/employees	17 (85%)	16 (80%)	19 (95%)
	If yes, did the assessment address staff knowledge and attitude about Māori and child abuse and neglect?	16 (80%)	15 (75%)	17 (85%)
4.3	How long has the hospital's child abuse and neglect programme been in existence?			
	a) 24–48 months			
	b) >48 months	20 (100%)	20 (100%)	20 (100%)
4.4	Does the DHB's child abuse and neglect programme address cultural issues?			
	a) does the DHBs policies specifically require implementation of the child abuse and neglect clinical assessment policy regardless of the child's cultural background?	20 (100%)	20 (100%)	20 (100%)
	b) does the child protection coordinator and the steering group work with the Māori health unit and other cultural/ethnic groups relevant to the DHBs demographics?	19 (95%)	20 (100%)	20 (100%)
	c) Are cultural issues discussed in the hospital's child abuse and neglect training programme?	20 (100%)	20 (100%)	20 (100%)
	d) are translators/interpreters available for working with victims if English is not the victim's first language?	20 (100%)	20 (100%)	20 (100%)
	e) Are referral information and brochures related to child abuse and neglect available in languages other than English?	19 (95%)	18 (90%)	17 (85%)
4.5	Does the DHB participate in prevention outreach/public education activities on the topic of child abuse and neglect?	19 (95%)		
	a) 1 programme in the last 12 months?	3 (15%)	2 (10%)	3 (15%)
	b) >1 programme in the last 12 months?	16 (80%)	18 (90%)	16 (80%)
	c) Does the DHB collaborate with Māori community organisations and providers to deliver preventive outreach and public education activities?	19 (95%)	18 (90%)	17 (85%)
4.6	Do policies and procedures indicate the availability of supportive interventions for staff who have experienced abuse and neglect, or who are perpetrators of abuse and neglect?	20 (100%)	20 (100%)	19 (95%)
	a) is a list of supportive interventions available?	20 (100%)	20 (100%)	19 (95%)
	b) are staff aware of how to access support and interventions available?	20 (100%)	20 (100%)	19 (95%)

	"YES" responses (highlighted cells < 80%)	2015 FU DHBs (%)	2016 FU DHBs (%)	2017 FU DHBs (%)
4.7	Is there evidence of coordination between the DHB child abuse and neglect programme in collaboration with other violence intervention programmes?	20 (100%)		
%)	20 (100%)	20 (100%)		
	a) is there is a referral mechanism?	19 (100%)	19 (95%)	20 (100%)
4.8	Does the child protection policy require mandatory use of DHB approved translators when English is not the victim's or caregiver's first language?			
	a) DHB approved translators being used?	20 (100%)	19 (95%)	19 (95%)
	b) a list of translators is accessible?	20 (100%)	19 (95%)	18 (80%)
	c) translators used that are gender and age appropriate?	16 (80%)	17 (85%)	15 (75%)
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 (95%)	19 (95%)	18 (90%)
	b) access to child abuse and neglect training?	20 (100%)	20 (100%)	18 (90%)
	c) coordination of referral processes between the DHB and primary health care sectors?	19 (95%)	17 (85%)	17 (85%)
	d) ongoing relationships and activities that focus on prevention and promoting child protection?	20 (100%)	20 (100%)	20 (100%)
CATEGORY 5. TRAINING OF PROVIDERS				
5.1	Is there evidence of a formal training plan that is specific to child abuse and neglect for clinical staff and non-clinical staff?			
	a) a strategic plan for training?	20 (100%)	18 (90%)	19 (95%)
	b) an operational plan that outlines the specifics of the programme of training?	20 (100%)	19 (95%)	18 (90%)
	c) Does the plan include the provision of regular, ongoing education for clinical staff?	20 (100%)	19 (95%)	18 (90%)
	d) Does the plan include the provision of regular, ongoing education for non-clinical staff?	20 (100%)	15 (75%)	13 (65%)
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?	20 (100%)	20 (100%)	20 (100%)
	b) to members of the clinical staff via colloquia or other sessions?	20 (100%)	20 (100%)	20 (100%)
5.3	Does the training/education on child abuse and neglect include information about:			
	a) definitions of child abuse and neglect?	20 (100%)	20 (100%)	20 (100%)
	b) dynamics of child abuse and neglect?	20 (100%)	20 (100%)	20 (100%)
	c) child advocacy?	20 (100%)	20 (100%)	20 (100%)
	d) appropriate child-centred interviewing?	20 (100%)	20 (100%)	20 (100%)
	e) issues of contamination?	19 (95%)	20 (100%)	19 (95%)
	f) ethical dilemmas?	20 (100%)	20 (100%)	20 (100%)

	"YES" responses (highlighted cells < 80%)	2015 FU DHBs (%)	2016 FU DHBs (%)	2017 FU DHBs (%)
	g) conflict of interest?	20 (100%)	20 (100%)	20 (100%)
	h) epidemiology?	20 (100%)	20 (100%)	20 (100%)
	i) health consequences?	20 (100%)	20 (100%)	20 (100%)
	j) identifying high risk indicators?s	20 (100%)	20 (100%)	20 (100%)
	k) physical signs and symptoms?	20 (100%)	20 (100%)	20 (100%)
	l) dual assessment with partner violence?	20 (100%)	20 (100%)	20 (100%)
	m) documentation?	20 (100%)	20 (100%)	20 (100%)
	n) intervention?	20 (100%)	20 (100%)	20 (100%)
	o) safety planning?	20 (100%)	20 (100%)	20 (100%)
	p) community resources?	20 (100%)	20 (100%)	20 (100%)
	q) child protection reporting requirements?	20 (100%)	20 (100%)	20 (100%)
	r) linking with the police and child youth and family?	20 (100%)	20 (100%)	20 (100%)
	s) limits of confidentiality?	20 (100%)	20 (100%)	20 (100%)
	t) age appropriate assessment and intervention?	20 (100%)	20 (100%)	20 (100%)
	u) cultural issues?	20 (100%)	20 (100%)	20 (100%)
	v) link between partner violence and child abuse and neglect?	20 (100%)	20 (100%)	20 (100%)
	w) Māori models of health?	19 (95%)	19 (95%)	19 (95%)
	x) the social, cultural, historic, and economic context in which Māori family violence occurs?	20 (100%)	20 (100%)	20 (100%)
	y) Te Tiriti o Waitangi?	20 (100%)	20 (100%)	20 (100%)
	z) Māori service providers and community resources?	20 (100%)	19 (95%)	19 (95%)
	aa) service providers and community resources for ethic and cultural groups other than Pakeha and Māori?	19 (95%)	18 (90%)	19 (95%)
	ab) If all sub-items are evident, bonus 1.5	19 (95%)	18 (90%)	19 (95%)
5.4	Is the child abuse and neglect training provided by: (choose one of a-d and answer e-f)			
	c) a team of DHB employees only?	1 (5%)	1 (5%)	2 (10%)
	d) a team, including community expert(s)?	19 (95%)	19 (95%)	18 (90%)
	e) a Child Youth and Family statutory social worker?	20 (100%)	20 (100%)	20 (100%)
	f) a Māori representative?	18 (90%)	18 (90%)	17 (85%)
	g) a representative(s) of other ethnic/cultural groups?	12 (60%)	10 (50%)	11 (55%)

	"YES" responses (highlighted cells < 80%)	2015 FU DHBs (%)	2016 FU DHBs (%)	2017 FU DHBs (%)
5.5	Is the training delivered in collaboration with various disciplines, and providers of child protection services, such as CYF, Police and community agencies?	20 (100%)	20 (100%)	20 (100%)
5.6	Does the plan include a range of teaching and learning approaches used to deliver training on child abuse and neglect?	20 (100%)	19 (95%)	20 (100%)
CATEGORY 6. INTERVENTION SERVICES				
6.1	Is there a standard intervention checklist for staff to use/refer to when suspected cases of child abuse and neglect are identified?	20 (100%)	20 (100%)	20 (100%)
6.2	Are child protection services available "on-site"? If yes, choose one of a–b and answer c–d:			
	a) A member of the child protection team or social worker provides services during certain hours.	5 (25%)	4 (20%)	3 (15%)
	b) A member of the child protection team or social worker provides service at all times.	15 (75%)	16 (80%)	17 (85%)
	c) A Māori advocate or social worker is available "on-site" for Māori victims.	19 (95%)	19 (95%)	20 (100%)
	d) An advocate of ethnic and cultural background other Pakeha and Māori is available onsite.	15 (75%)	18 (90%)	17 (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)			
	a) available, when indicated?	13 (65%)	11 (55%)	10 (50%)
	b) performed routinely?	7 (35%)	9 (45%)	10 (50%)
	c) age-appropriate?	20 (100%)	20 (100%)	20 (100%)
6.4	Do the intervention services include:			
	a) access to physical and sexual examination?	20 (100%)	20 (100%)	20 (100%)
	b) access to specialised sexual abuse services?	20 (100%)	20 (100%)	20 (100%)
	c) family focused interventions?	19 (95%)	19 (95%)	19 (95%)
	d) support services that include relevant NGOs, or acute crisis counsellors/support?	20 (100%)	20 (100%)	20 (100%)
	e) culturally appropriate advocacy and support?	20 (100%)	20 (100%)	20 (100%)
6.5	Are Social Workers available?			
	a) Monday to Friday 8 am to 4 pm service, with referrals outside of these hours?	10 (50%)	7 (35%)	4 (20%)
	b) On-call after 4 pm and at weekends?	4 (20%)	4 (20%)	4 (20%)
	c) as a 24-hour service?	6 (30%)	9 (45%)	12 (60%)
6.6	Is there a current list of relevant services available to support child and family safety?	20 (100%)	19 (95%)	20 (100%)
6.7	Is provision made for transport for victims and their families, if needed?	20 (100%)	20 (100%)	20 (100%)
6.8	Does the DHB child abuse and neglect programme include follow-up contact and counselling with victims after the initial assessment?	20 (100%)	20 (100%)	20 (100%)

	"YES" responses (highlighted cells < 80%)	2015 FU DHBs (%)	2016 FU DHBs (%)	2017 FU DHBs (%)
6.9	Does the child abuse and neglect programme assess and provide family violence intervention services and appropriate referral for:			
	a) the mother	20 (100%)	20 (100%)	20 (100%)
	b) siblings	20 (100%)	20 (100%)	20 (100%)
6.10	Is there evidence of coordination with CYF and the Police for children identified at risk of child abuse and neglect?	20 (100%)	20 (100%)	20 (100%)
CATEGORY 7. DOCUMENTATION				
7.1	Is there evidence of use of a standardised documentation form to record known or suspected cases of child abuse and neglect, and safety assessments? If yes, does the form include:			
	a) Reason for presentation?	20 (100%)	20 (100%)	20 (100%)
	b) information generated by risk assessment?	19 (95%)	19 (95%)	19 (95%)
	c) the victim or caregiver's description of current and/or past abuse?	20 (100%)	19 (95%)	19 (95%)
	d) the name of the alleged perpetrator and relationship to the victim?	19 (95%)	17 (85%)	18 (80%)
	e) a body map to document injuries?	20 (100%)	20 (100%)	20 (100%)
	f) Past medical history?	20 (100%)	20 (100%)	20 (100%)
	g) A social history, including living circumstances?	20 (100%)	19 (95%)	20 (100%)
	h) An injury assessment, including photographic evidence (if appropriate)?	20 (100%)	19 (95%)	20 (100%)
	i) The interventions undertaken?	20 (100%)	20 (100%)	20 (100%)
	j) information documenting the referrals provided to the victim and their family?	20 (100%)	20 (100%)	20 (100%)
	k) in the case of Māori, information documenting whether the victim and their family were offered a Māori advocate?	18 (90%)	18 (90%)	17 (85%)
7.2	Does the DHB have sexual abuse specific forms that include:			
	a) a genital diagram?	16 (80%)	16 (80%)	17 (85%)
	b) a consent form?	17 (85%)	20 (100%)	17 (85%)
7.3	Is there evidence of use of a standardised referral form and process for CYF and/or Police notification? If yes, is a referral form and process available for:			
	a) CYF notification?	20 (100%)	20 (100%)	20 (100%)
	b) Police notification?	14 (70%)	15 (75%)	16 (80%)
7.4	Are staff provided training on documentation for children regarding abuse and neglect?	20 (100%)	19 (95%)	20 (100%)

	"YES" responses (highlighted cells < 80%)	2015 FU DHBs (%)	2016 FU DHBs (%)	2017 FU DHBs (%)
CATEGORY 8. EVALUATION ACTIVITIES				
8.1	Are any formal evaluation procedures in place to monitor the quality of the child abuse and neglect programme? If yes:			
	a) Do evaluation activities include periodic monitoring of implementation of child abuse and neglect clinical assessment policy?	19 (95%)	18 (90%)	18 (90%)
	b) Is the evaluation process standardised?	17 (85%)	16 (80%)	15 (75%)
	c) Do evaluation activities measure outcomes, either for entire programme or components thereof?	18 (90%)	18 (90%)	18 (90%)
	d) Does the evaluation of the programme include relevant review/audit of the following activities:			
	Identification, risk assessment, admissions and referral activities?	17 (85%)	16 (80%)	15 (75%)
	Monitoring trends re demographics, risk factors, and types of abuse?	15 (75%)	17 (85%)	16 (80%)
	Documentation?	17 (85%)	16 (80%)	17 (85%)
	Referrals to CYF/Oranga Tamariki and the Police?	18 (90%)	18 (90%)	18 (90%)
	Case reviews?	19 (95%)	15 (75%)	17 (85%)
	Critical incidents?	19 (95%)	19(95%)	19(95%)
	Mortality morbidity review?	17 (85%)	18 (90%)	19 (95%)
	Policy and procedure reviews?	20 (100%)	19 (95%)	20 (100%)
	e) Do the evaluation activities include:			
	Multidisciplinary team members?	20 (100%)	19 (95%)	19 (95%)
	Police?	17 (85%)	17 (85%)	16 (80%)
	CYF/Oranga Tamariki?	20 (100%)	18 (90%)	17 (85%)
	Community agencies?	16 (80%)	15 (75%)	15 (75%)
8.2	Is there evidence of feedback on the child abuse and neglect programme from community agencies and government services providers, such as CYF/Oranga Tamariki, the Police, refuge, and well child providers?	17 (85%)	17 (85%)	17 (85%)
8.3	Do health care providers receive standardized feedback on their performance and on patients from CYF/ Oranga	14 (70%)	13 (65%)	17 (85%)
8.4	Is there any measurement of client satisfaction and community satisfaction with the child abuse and neglect programme?			
	a) client satisfaction?	8 (40%)	7 (35%)	7 (35%)
	b) community satisfaction?	17 (85%)	14 (70%)	14 (70%)

	"YES" responses (highlighted cells < 80%)	2015 FU DHBs (%)	2016 FU DHBs (%)	2017 FU DHBs (%)
8.5	Is a quality framework used to evaluate whether services are effective for Māori?	8 (40%)	9 (45%)	9 (45%)
8.6	Are data related to child abuse and neglect assessments, identifications, referrals and alert status recorded, collated and reported on to the DHB?	16 (80%)	18 (90%)	18 (90%)
8.7	Is the child abuse and neglect programme evident in the DHB quality and risk programme?	19 (95%)	19 (95%)	18 (90%)
8.8	Is the responsibility for acting on evaluation recommendations specified in the policies and procedures?	17 (85%)	17 (85%)	18 (90%)
CATEGORY 9. PHYSICAL ENVIRONMENT				
9.1	How many locations with posters/images relevant to children and young people which are they child-friendly, contain messages about child rights and safety, and contain Māori and other relevant cultural or ethnic images?			
	a) <10 posters or images	0 (0%)	1 (5%)	0 (0%)
	b) 10–20 posters or images	2 (10%)	3 (15%)	3 (15%)
	c) >20 posters or images	16 (80%)	15 (75%)	16 (80%)
9.2	Is there referral information (local or national phone numbers) related to child advocacy and relevant services on public display in the DHB? (Can be included on the posters/brochure noted above).			
	a) <10 locations	1 (5%)	1 (5%)	0 (0%)
	b) 10–20 locations	4 (20%)	5 (25%)	4 (20%)
	c) >20 locations	15 (75%)	14 (70%)	16 (80%)
9.3	Are there designated private spaces available for interviewing?			
	a) > 4 locations?	19 (100%)	19 (95%)	20 (100%)
9.4	Does the DHB provide temporary (<24 hours) safe shelter for victims of child abuse and neglect and their families who cannot go home or cannot be placed in a community-based shelter until CYF or a refuge intervene?			
	a) 'Social admissions" mentioned in child abuse and neglect policies?	17 (85%)	18 (90%)	17 (85%)
	b) Temporary safe shelter is available?	19 (95%)	19 (95%)	19 (95%)

APPENDIX L. DHB SERVICES ACHIEVING ASSESSMENT & IDENTIFICATION TARGET RATES (2017)

	District Health Board							
SERVICE	Auckland	Bay of Plenty	Canterbury	Midcentral	Nelson Marlborough	South Canterbury	Tairawhiti	Taranaki
Intimate Partner Violence								
Assessment > 80% and Disclosure > 5% (n=11)								
Postnatal Maternity (n=0)								
Child Health inpatient (n=1)								
Emergency Department (n=0)								
Sexual Health (n=6)								
Community Mental Health (2)								
Community Alcohol & Drug (2)								
Child Abuse and Neglect								
Assessment > 80% and Concern > 5% (n=2)								
Emergency Department (< 2 yrs. of age)								
Green = ACHIEVED target; Yellow = near target								


CENTRE FOR
INTERDISCIPLINARY TRAUMA RESEARCH
AUT UNIVERSITY

MINISTRY OF
HEALTH
MANATŪ HAUORA

VIP
violence intervention
programme

AUT