# HOSPITAL RESPONSIVENESS TO FAMILY VIOLENCE:

## *108 MONTH FOLLOW-UP EVALUATION*

MINISTRY OF HEALTH
MANATŪ HAUORA

VIP
violence intervention programme

Interdisciplinary Trauma Research Centre
Te wairere au noa

AUT
UNIVERSITY

# HOSPITAL RESPONSIVENESS TO FAMILY VIOLENCE:
# 108 MONTH FOLLOW-UP EVALUATION

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This evaluation project was approved by the Multi-region Ethics Committee (AKY/03/09/218, including annual renewal to 5 December 2013).

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



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## EXECUTIVE SUMMARY

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

This report documents the result of measuring system indicators at 20 DHBs, providing Government, MOH and DHBs with information on family violence intervention programme implementation. Based on programme maturity, 16 DHBs completed a self audit for the 108 month follow-up audit; the remaining 4 were independently audited (including site visits). All data are based on the combined self audit and external audit scores for 2012/2013. The median DHBs score was 92 (possible range 0 to 100) for partner abuse and child abuse and neglect programmes (Figure 1).

- *95% of DHBs achieved the target score (≥ 70) for both partner abuse and child abuse and neglect intervention programmes at 30 June 2013.*

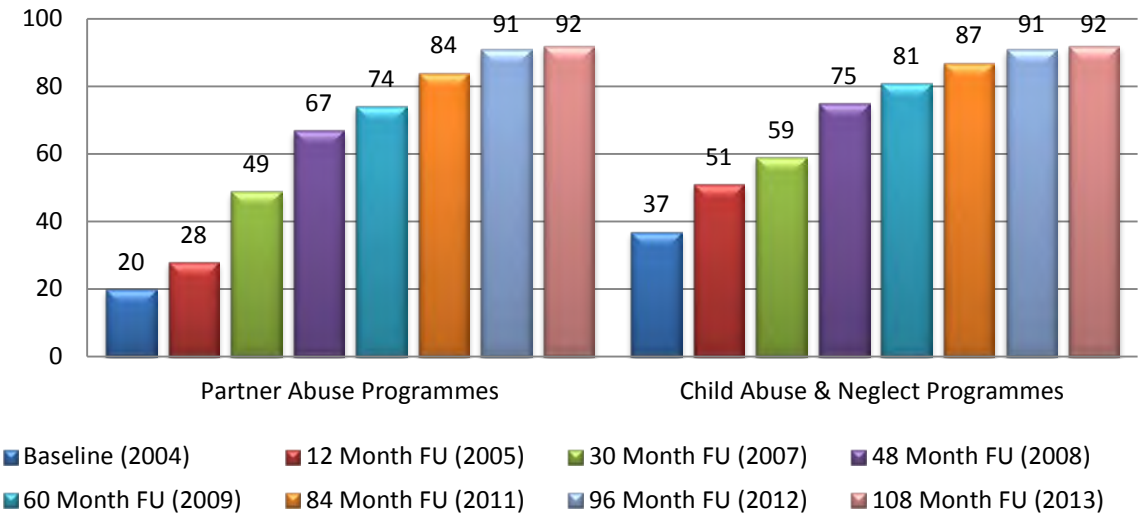



*Figure 1.* Median Violence Intervention Programme (VIP) Scores (2004-2013)

- 95% (n=19) of DHBs have VIP systems in place to support an efficient, safe response to those experiencing partner abuse and child abuse and neglect.
- Roll out of staff training and delivery of VIP services is occurring across designated services (emergency, maternity, child health, sexual health, mental health and alcohol and drug).
- At the time of the audit, 100% (n=20) of DHBs had a dedicated VIP coordinator position (at least 1 FTE or equivalent).
- 95% (n=19) of DHBs had been approved to deliver the Ministry-approved standardised national VIP training package.

- 65% (n=13) of DHBs had a VIP Quality Improvement Plan at the time of the audit.
- Internal audit processes monitoring policy implementation remain variable across DHBs, despite the VIP QI Toolkit resource.
- Internal chart review summaries indicated 45% (n=9) of DHBS are screening at least half of all eligible women for partner violence, an increase from 30% (96 month follow-up).

VIP recognises culturally responsive health systems contribute to reducing health inequalities. Cultural responsiveness scores continue to increase over time. Overall DHB VIP cultural responsiveness scores increased 3% and 2% since the previous audit for partner abuse and child abuse and neglect programmes respectively. A VIP Whānau-Centred Management Contract with Jigsaw continues to support programmes in applying the principles of Whānau-Centred Care[1] and to achieve cultural indicators that performed poorly in past audit periods (see page 20).

While programmes are doing well overall, there are still significant gaps. Improved leadership, coordination, quality monitoring and evaluation activities are required to enhance programme integration and effectiveness.

As DHBs are supported to self audit their implementation of VIP in designated health services, it is important to focus on quality improvement initiatives. These include improving partner abuse identification, disclosure rates and appropriate interventions; and improving the identification and assessment of children with actual or suspected abuse supported by appropriate multi-disciplinary review and referral. The Ministry supported the delivery of five regional quality improvement one-day training workshops in mid-2013. These workshops, based on the IHI Model for Improvement, increased DHB knowledge in quality improvement methods and measuring for both accountability and for improvement. The focus is now on increasing the quality of services to vulnerable women and children.

## BACKGROUND

Family violence (FV) is recognised to have significant social, economic, and health tolls internationally and in Aotearoa New Zealand.[2-8] With the identification of family violence as a preventable public health problem,[9] the Ministry of Health ('the Ministry') began a Family Violence Health Intervention Project in 2001 (see Appendix A). In 2007, The Ministry launched the renamed Violence Intervention Programme (VIP) in District Health Boards (DHBs). VIP seeks to reduce and prevent the health impacts of violence and abuse through early identification, assessment and referral of victims presenting to health services. This programme is part of the health sector response which is one component of the multi-agency approach to reduce family violence in New Zealand led by Government's Taskforce for Action on Violence within Families[10] and more recently, the Children's Action Plan, 2012[11] and the government priority to reduce the number of assaults on children (Better Public Services Key Result Action Area, 2013).[12]

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

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

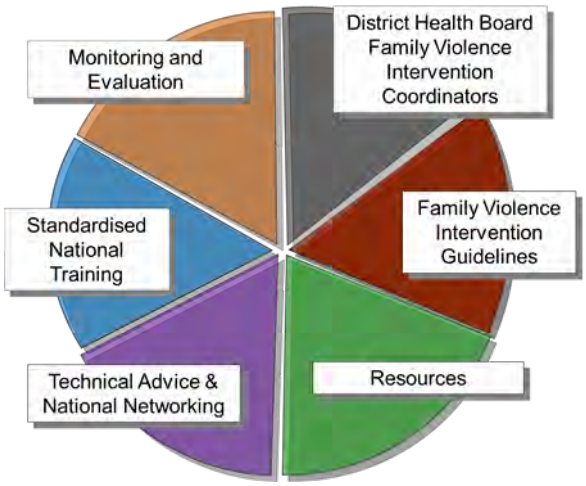



*Figure 2. Ministry of Health VIP Systems Support Model (Secondary Care)*

The VIP external evaluation project, operating since 2003, provides information to DHBs and the Ministry about the implementation of family violence programmes.[a] This 108 month follow-up report documents the development of DHB family violence systems across eight rounds of hospital audits. This longitudinal data contribute to the nationwide picture of family violence healthcare initiatives across Aotearoa New Zealand acute care services. The quantitative data are the result of applying standardised audit tools to measure system indicators across 20 District Health Boards at 27 hospitals.

The 108 month follow-up evaluation mirrored the 96 month follow-up[13] evaluation processes with the following changes:

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

- All 20 DHBs submitted self audits; based on programme maturity, 4 selected DHBs (Lakes, Hutt Valley, Southern and Northland) also participated in an independent audit that included site visits.
- The unit of analysis for the 108 month follow up audit data was DHB (n=20); previously, hospital (n=27) had been the unit of analysis (see page 8).

The transition to self audit processes recognises increasing programme maturity across DHBs and supports identification of strengths, weaknesses, opportunities for improvement and prevention of problems.[14,15]

This evaluation sought to answer the following questions:

1. How are New Zealand District Health Boards performing in terms of institutional support for family violence prevention?
2. Is institutional change sustained over time?
3. Do self audit scores accurately represent programme system development?

The evaluation is an important component of the Ministry's efforts to reduce and prevent the health impacts of family violence by implementing quality early intervention programmes in clinical and other health services. It also contributes to the whole of government priorities on protecting vulnerable children (as outlined in the White Paper for Vulnerable Children and Children's Action Plan,[11] and Better Public Services Targets[12]) and contributing to Whānau Ora.[1] The evaluation data supports an evidence-based programme, providing information to guide DHB and Ministry decisions and resource investment.

## METHODS

Participation in the audit process was specified in Ministry VIP contracts with DHBs. One hundred and eight month follow up audits were conducted in the 20 DHBs across New Zealand (see Appendix B). The evaluation project was approved by the Multi-region Ethics Committee (AKY/03/09/218 with annual renewal including 5/12/13).

All DHBs were invited to submit self audit data 12 months following their previous audit. FVIC were requested to complete and forward self audit documentation including:

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

Details about the audit tools are provided in the following section (page 6). The Programme Information Form (Appendix C) inquired about DHB resources, programme diffusion across services and internal clinical audit results. In the self audit report, DHBs were asked to identify their programme strengths and areas for improvements, and to provide an action plan.

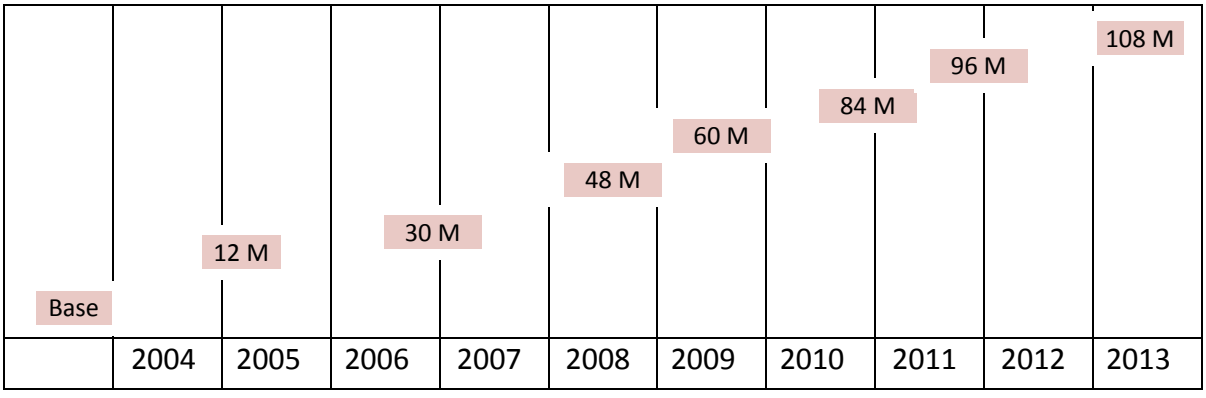
In addition to self-audit, external audit site visits were conducted at 4 DHBs (Table 1). The 4 DHBs were independently audited as they were considered to be undergoing significant system change by the VIP Management Group.

108 month follow-up self and external audit data were collected between April and July 2013.

*Table 1. Self and External Audit Assignments for 108 month follow up*

| Self Audit Only (16 DHBs) | External & Self audit 4 DHBs) |
|---|---|
| Auckland | Hutt Valley |
| Bay of Plenty | Lakes |
| Canterbury | Northland |
| Capital & Coast | Southern |
| Counties Manukau | |
| Hawke's Bay | |
| MidCentral | |
| Nelson Marlborough | |
| South Canterbury | |
| Southern | |
| Tairawhiti | |
| Taranaki | |
| Waikato | |
| Wairarapa | |
| Waitemata | |
| West Coast | |
| Whanganui | |

The eight audit round periods are shown in Figure 3.




Note: M=months from baseline.

*Figure 3.* Audit Round Time Periods

## Audit Tools

Quantitative external and self audit data were collected applying the *Partner Abuse (PA) Programme Evaluation Tool* and *Child Abuse and Neglect (CAN) Programme Evaluation Tool*. These tools reflect modifications of the *Delphi Instrument for Hospital-Based Domestic Violence Programmes*[16-18] for the bicultural Aotearoa New Zealand context. The audit tools assess programmes against criteria for an ideal programme given current knowledge and expertise.

The Partner Abuse (*PA) Tool* has been used without change across all audit periods. In 2007, a Delphi process with a New Zealand expert panel was conducted to revise the Child Abuse and Neglect (*CAN) Tool* to improve its content validity.[19] This *Revised CAN Tool* was subsequently used for the 48, 60, 84, 96 and 108 month follow-up audits. The revised tool included an additional 28 indicators and a new *Safety and Security* domain. The 48 month follow up report[20] includes a comparison of the original and revised tool.

The audit tools have been available (open access at www.aut.ac.nz/vipevaluation) as interactive Excel files since 2008. This format allows users to see measurement notes, enter their indicator data and be provided score results.

The 64 performance measures in the *Revised CAN Tool* and 127 performance measures in the *PA Tool* are categorised into nine domains (see Table 2). The *Screening and Safety Assessment* domain is unique to the PA tool; the *Safety and Security* domain is unique to the CAN tool. The domains reflect components consistent with a systems model approach.[21-23] Each domain score is standardised resulting in a possible score from 0 to 100, with higher scores indicating greater levels of programme development. An overall score is generated using a scheme where some domains are weighted higher than others (see Appendix D for domain weights).

*Table 2*. Audit Tool Domains

| | |
|---|---|
| Policies and Procedures | •policies and procedures outline assessment and treatment of victims; mandate identification and training; and direct sustainability |
| Safety and Security | •children and young people are assessed for safety, safety risks are identified and security plans implemented [CAN tool only] |
| Physical Environment | •posters and brochures let patients and vistors know it is OK to talk about and seek help for family violence |
| Institutional Culture | •family violence is recognised as an important issue for the health organisation |
| Training of Providers | •staff receive core and refresher training to identify and respond to family violence based on a training plan |
| Screening and Safety Assessment | •standardised screening and safety assessments are performed [PA tool only] |
| Documentation | •standardised family violence documentation forms are available |
| Intervention Services | •checklists guide intervention and access to advocacy services |
| Evaluation Activities | •activities monitor programme efficiency and whether goals are achieved |
| Collaboration | •internal and external collaborators are involved across programme processes |

Recognising that culturally responsive health systems contribute to reducing health inequalities, indicators addressing Māori, Non-Māori non-Pakeha (e.g. Pacific Island, Asian, migrant and refugee) and general cultural issues for planning and implementing a family violence response in the health sector have been integrated within the Partner Abuse (n=30) and Child Abuse and Neglect (n=28) audit tools. These items contribute to a cultural responsiveness score, standardised to range from 0 to 100.[24]

## Procedure

Evaluation procedures were conducted based on a philosophy of supporting programme leaders in building a culture of improvement. Integrating the evaluation into the VIP systems approach allowed for clear and consistent communication and resources to support audit activities. Details of evaluation processes are outlined in Figure 4 and Appendix E. The 108 month follow up process began on 14 March 2013 with a letter from the Ministry advising DHB Chief Executives of the upcoming 2013 audit round.

Shortly after DHB notification by the Ministry, external audit staff contacted VIP managers and FVIC by e-mail to outline whether they were scheduled for self audit only (n=16), or self audit followed by external audit (n=4). A confirmatory e-mail identified site visit dates for DHBs scheduled for an external audit.

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

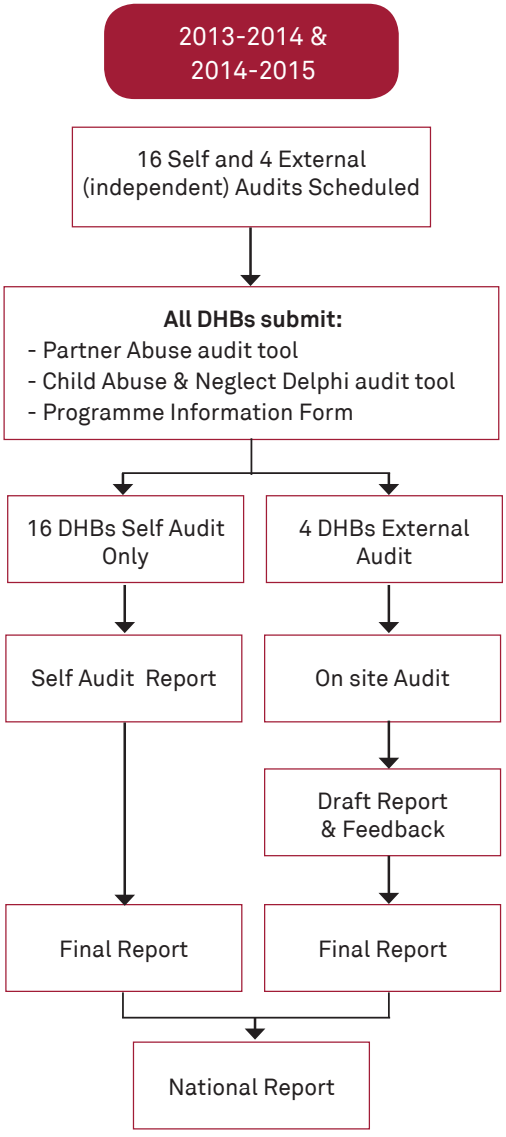



*Figure 4.* 2012-2015 Audit Plan

## Reporting

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

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

## Analysis Plan

Self and external audit data were exported from Excel audit tools into an SPSS Statistics (Version 20) file. Score calculations were confirmed between Excel and SPSS files. Programme information (Appendix C) data were also entered into an SPSS file. All analyses were conducted in SPSS.

Analysis began with assessment of agreement between self audit and external audit values for all indicators, domain and overall scores among the 4 DHBs that had both self and external audit data. The decision was then made to amalgamate the external and self audit scores. This means that 108 month follow up scores represent external audit scores for the 4 DHBs that had an external evaluation and self audit scores for the remaining 16 DHBs.

- *108 month follow up results combine self audit scores for 16 DHBs and external audit scores for 4 DHBs.*

Infrastructure monitoring in 2013/14 will again involve all DHBs conducting a self audit, with data collation by external evaluators. External audits (including site visits) will be conducted in four selected DHBs. Additionally, a national 'snapshot' of selected deliverables is planned for 2013/14 and 2014/2015.

In this report we present baseline, 12, 30, 48, 60, 84, 96 and 108 month follow-up domain and overall Delphi scores for comparison. Box plots and league tables are used to examine the distribution of scores over time (see Appendix F: *How to Interpret Box Plots*). The 108 month follow up audit introduced DHBs as the unit of analysis. Previous audits had maintained hospitals as the unit of analysis across evaluation reports with the exception of league tables and some indicator reporting, which were reported by DHB. This change was implemented due to the lack of variation within DHBs and that the management of the programme (and reporting to the Ministry) occurs by DHB. Recognising the potential of individual extreme scores to influence mean scores, we favour reporting medians (and box plots).

# FINDINGS

## Partner Abuse Programmes

- *At the 108 month follow-up, the partner abuse intervention programme score ranged from 53 to 100, with 92 as the typical (median) score.*
- *95% of DHBs achieved an overall partner abuse programme score ≥ 70.*

As demonstrated in Figure 5, partner abuse programme scores have increased substantially over time. With programme maturity, the median score increased from 91 at the 96 month follow up audit to 92 at the 108 month follow up. Due to VIP restructuring in one DHB, the proportion of DHBs achieving the minimal achievement target score of 70 dropped from 100% to 95% between the 96 and 108 month follow up audits. Appendix G provides the data supporting the Figures and Tables in this section.

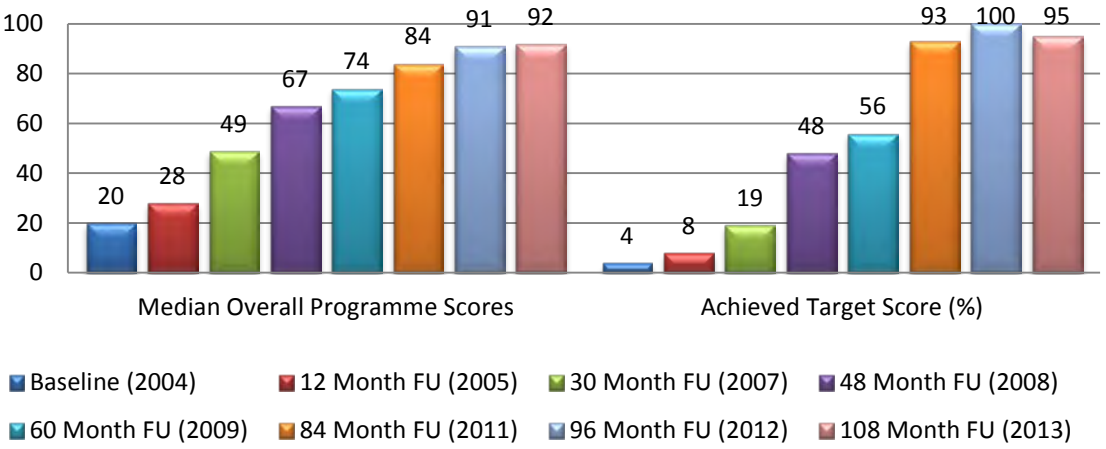



*Figure 5.* Partner Abuse Programme Scores 2004-2013

Variability in scores over time is shown in Figure 6. At baseline, scores were consistently (SD=18.1) at the lower range of the scale, with a single high scoring outlier. This was followed by a period of wide score variation peaking at the 30 month follow up audit (SD at 12, 30, 48 and 60 month audits = 21.9, 26.2, 21.6 and 20.1 respectively), indicating a period of change. At the 84, 96 and 108 month follow ups, audit scores were again consistent (SD=11.5, 6.3, 12.5).

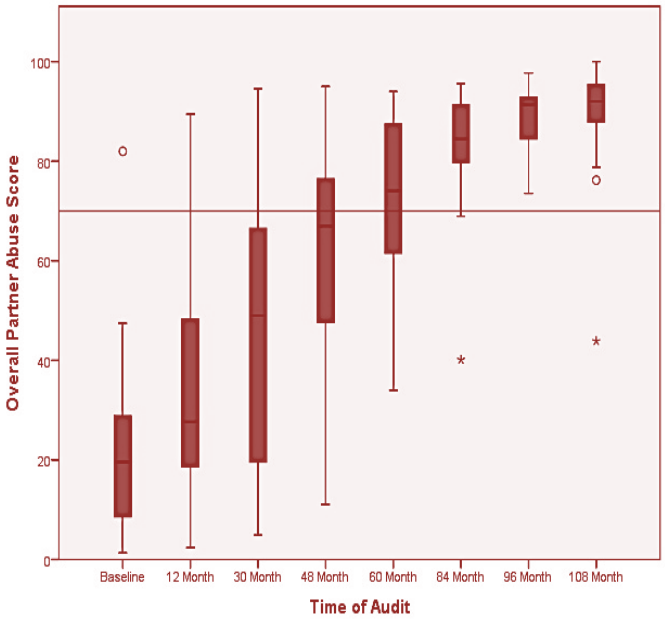



*Figure 6.* Overall Partner Abuse Score Distributions over Time

## Partner Abuse Programme Indicators

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

*100% (n=20) of DHBs employ an identifiable partner abuse intervention programme coordinator.*

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

*95% (19) of DHBs have endorsed policies regarding the assessment and treatment of victims of partner abuse.*

*95% (19) of DHBs have instituted partner abuse screening in one or more services.*

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

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

*85% (n=17) of DHBs have written procedures outlining security's role in working with partner abuse victims and perpetrators.*

*75% (n=15) of DHBs have an Employee Assistance Programme (or similar) that maintains specific policies and procedures for responding to employees experiencing partner abuse.*

The Ministry funds DHBs to implement VIP (integrating partner abuse and child abuse and neglect services) in the following six targeted services:

- Child Health
- Maternity
- Sexual Health
- Mental Health
- Alcohol and Drug
- Emergency Department

Most DHBs are still in the process of programme diffusion across services. The number of DHBs delivering VIP assessment and intervention by service is shown in Figure 7. Some DHBs have only implemented VIP in one targeted service (either the Emergency Department or Child Health). In some cases, such as sexual health, services may be offered regionally. A few DHBs support VIP implementation beyond the identified Ministry targeted services (such as in medical wards and primary care services).

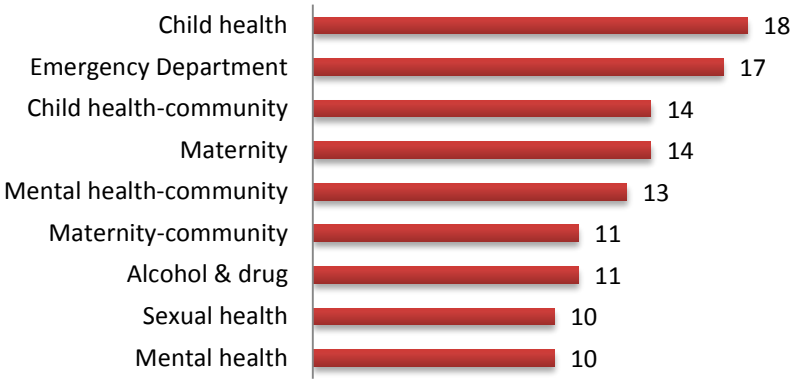


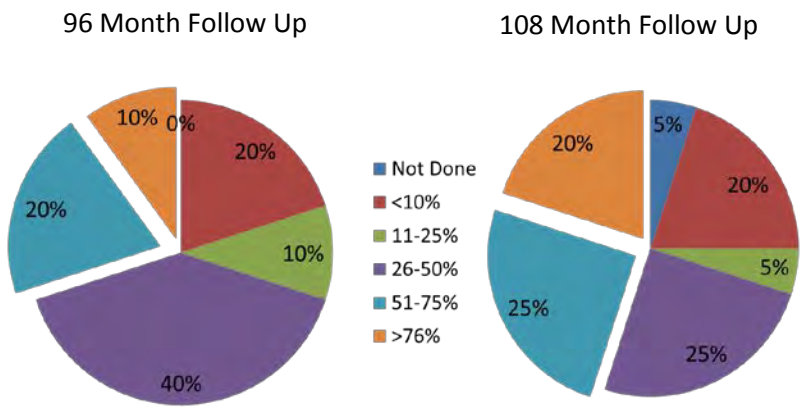

*Figure 7.* VIP Implementation By Service (number of DHBs)

As the majority of programmes have the infrastructure in place to support a systems approach for responding to partner abuse, there is increasing attention on evaluating service delivery. The diffusion of VIP across services (Figure 7), the rate of partner violence screening of eligible women within those services, and the provision of services to women who disclose abuse are useful measures of programme implementation outputs.[25]

To assist standardisation of data collection, the *Quality Improvement Toolkit* includes an Excel file for partner violence screening data entry and analysis. VIP staff are beginning to gain experience in standardising routine data collection (such as frequency of auditing and number of random charts selected), though for the most part, data collection remains variable. The summary data provided in the following section are indicative only. Further standardisation of data collection is needed to provide robust information to inform policy and practice.

## Clinical Audit: Partner Violence Screening and Disclosure

The proportion of eligible women screened for partner violence is improving over time based on self report of internal audit activities (Figure 8). It is encouraging that 45% of DHBs report screening at least half of eligible women in selected services. Equally, however, it demonstrates that increased attention is needed to promote the diffusion of partner violence screening in practice. The minimal target would be for all DHBs to screen at least 80% of eligible women across selected services.[26]




*DHBs reporting screening at least half of eligible women increased from 6 (30%) at the 96 month follow up to 9 (45%) at the 108 month follow up.*

*Figure 8.* Summary Screening Rate of Eligible Women

VIP service specifications require DHBs to report on the level of partner violence screening being undertaken across six targeted services: Child Health, Emergency Department, Maternity, Mental Health, Sexual Health, and Alcohol & Drugs. At the 108 month follow-up, only 10% (n=2) of the DHBs provided data for all six services (Table 3). This information identifies a need to continue support capability and capacity building to increase quality improvement activities across DHBs and services.

Across the data submitted by DHBs, there were often inconsistencies and incomplete data; the external auditors did not correct or follow up missing data. Data provided for 'other' services are not included in this report.

*Table 3. DHBs Reporting on Eligible Records Reviewed, Screened and Disclosed*

| Number of targeted services with performance data provided per DHB | Reporting number of eligible records reviewed | Reporting screening data | Reporting disclosure data |
|---|---|---|---|
| **0** | 6 | 5 | 5 |
| **1** | 3 | 4 | 4 |
| **2** | 1 | 0 | 0 |
| **3** | 4 | 4 | 5 |
| **4** | 3 | 4 | 4 |
| **5** | 1 | 0 | 0 |
| **6** | 2 | 3 | 2 |

The reported screening rates are provided in Figure 9 and Table 4. DHBs reported performance data for only a proportion of implementing services. For example, while 18 DHBs have implemented VIP in acute child health services; only 8 (44%) provided performance monitoring data. This is likely due to insufficient capability and capacity for routine performance monitoring. The lack of electronic data systems for family violence data is a serious limitation to the collection of data across the sector.

Among reporting DHBs, the median proportion of eligible women screened by service ranged from 24.3% for Acute Child Health service (with 8 DHBs reporting) to 95% for Community Child Health Service (with 5 DHBs reporting). Audit periods ranged from 1 week to one year with the exception of Maternity, where two DHBs had audit periods of one day. In other cases, the audit start and end dates are reported with no other data. These indicative screening rates are being reported to inform programme improvements. They indicate the need for quality improvement activities to increase the reliability of delivering a quality, consistent service to women.

The first step in improving system reliability is achieving a standard action at least 80% of the time (reference line in Figure 9).[26] Among the 50 reporting services across the 20 DHBs, 11 reported screening rates of at least 80%. Nationally, at least one Community Child Health, Sexual Health, Alcohol & Drug, Maternity and Emergency Department service was able to achieve a partner abuse screening rate at or above 80%. These locations present an opportunity to study what factors promote best practice.

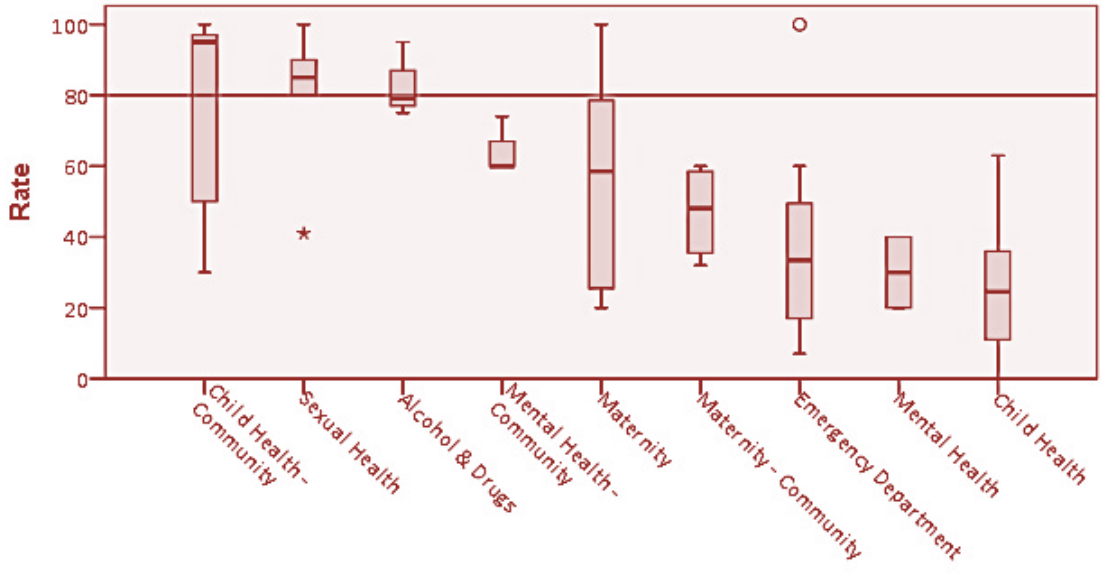



*Figure 9*. Partner Abuse Screening Rate by Service

*Table 4:* Partner Abuse Screening Data by Service

| Service | No. DHBs implementing VIP in service | No. DHBs reporting performance data | No. eligible records reviewed | Screening Rate Range | Screening rate Median |
|---|---|---|---|---|---|
| Child Health Community | 14 | 5 | 20-384 | 30-100 | 95% |
| Sexual Health Community | 10 | 5 | 20-400 | 41-100 | 85% |
| Alcohol & Drug | 11 | 3 | 4-24 | 75-95 | 79% |
| Mental Health Community | 13 | 3 | 10-20 | 60-74 | 60% |
| Maternity | 14 | 8 | 10-624 | 20-100 | 59% |
| Maternity Community | 13 | 4 | 20-62 | 32-60 | 48% |
| Emergency Department | 17 | 12 | 20-1497 | 7-100 | 34% |
| Mental Health | 10 | 2 | 10 | 20-40 | 30% |
| Child Health | 18 | 8 | 10-540 | 0-63 | 24% |

One measure of screening quality is the rate of partner violence identified as a result of direct questioning, the 'disclosure rate'. Research and practice identify that the quality of screening (including the environment, screening knowledge and attitude) will influence whether or not a woman will choose to disclose abuse.[27-29] With the estimated New Zealand population past year partner violence prevalence rates among women of 5%,[4,30] we would expect disclosure rates among women seeking health care to be at least that, and most likely higher given a higher use of health services among women who experience abuse.[31-33] Disclosure rates (based on screening for past year prevalence) would be expected to vary across services, with higher rates for example in mental health, alcohol and drug and sexual health services. This is the first evaluation audit that VIP disclosure rates have been reported.

There was wide variability in the disclosure rates, influenced by the number of DHBs reporting data (1 to 12), sample size, length of audit (1 day to one year) and the number of eligible records reviewed (Figure 10; Table 5). One DHB's Mental Health Service achieved a 50% disclosure rate for the sample of 10 eligible records reviewed. The median disclosure rate among 12 reporting emergency department was 8.35%; with audit samples that ranged from 20 to 1497 eligible records. Many services within DHBs reported a disclosure rate below 5% (the population one year period prevalence rate, reference line in Figure 10). A focus on standardisation, accurate reporting and quality improvement activities is expected to improve 2014 results. Implementing quality improvement strategies following the IHI Model for Improvement, with rapid plan-do-study-act cycles, is a useful method to learn about systems and increase the delivery of safe, sensitive partner violence assessment and intervention.[34]

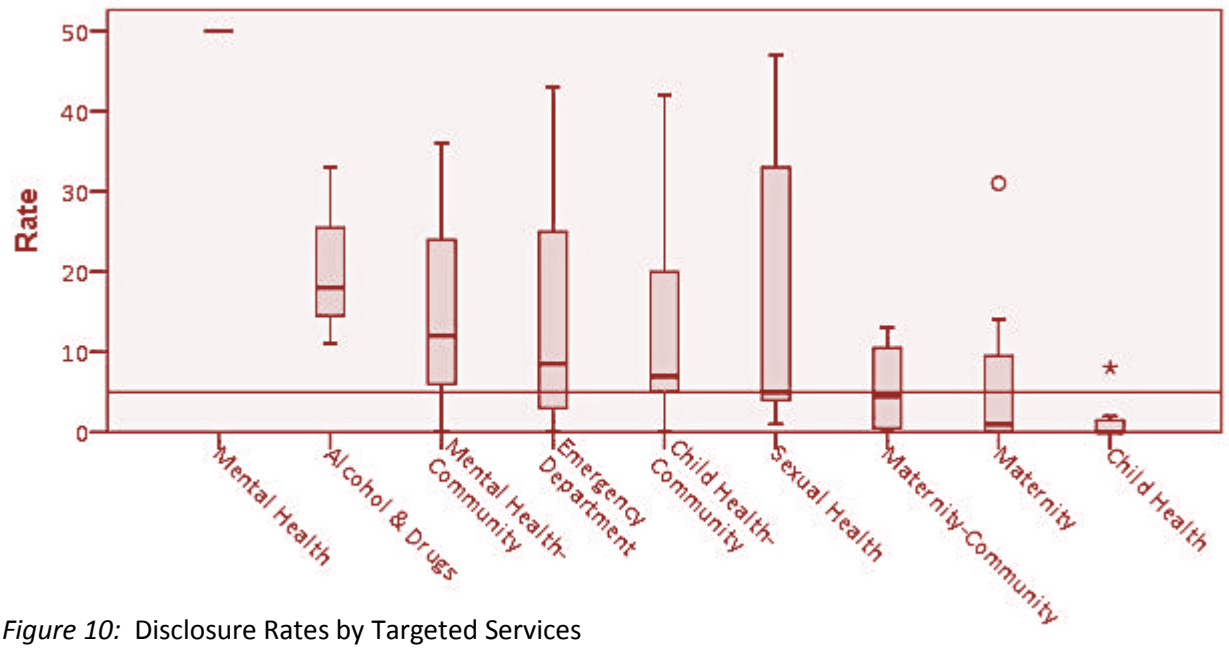



*Figure 10:* Disclosure Rates by Targeted Services

*Table 5:* Partner Abuse Disclosure Rates

| Service | No. of DHBs | No. eligible records reviewed | Range | Median |
|---|---|---|---|---|
| Mental Health | 1 | 10 | 50 | 50% |
| Alcohol & Drug | 3 | 4-24 | 11-33 | 18% |
| Mental Health Community | 3 | 10-20 | 0-36 | 12% |
| Emergency Department | 12 | 20-1497 | 0-43 | 8% |
| Child Health Community | 5 | 20-384 | 0-42 | 7% |
| Sexual Health | 5 | 20-400 | 1-47 | 5% |
| Maternity Community | 4 | 10-62 | 0-13 | 5% |
| Maternity | 7 | 10-624 | 0-31 | 0.5% |
| Child Health | 7 | 10-540 | 0-8 | 0 |

Other potential measures of service delivery are the rates of completed risk assessment, including assessment of children in the home, and provision of specialised family violence services (at the time or through referral) to women who disclose abuse. This data is not routinely collated, analysed and reported. Most DHBs (16, 80%) measure community satisfaction with the partner abuse programme, such as by Refuge services and Police. Few DHBs, however, include gathering client satisfaction data, necessary to advancing client-[35] and whānau-centred care.[1]

## Partner Abuse Programme Domains[a]

All nine partner abuse programme domain scores remained stable between the 96 and 108 month follow-up audits (Figure 11). All median domain scores have exceeded the target score of 70 for two consecutive audit periods.

*Evaluation Activities* (median=80) and *Screening and Safety Assessment* (median=85) are the two lowest scoring domains. Both domains are influenced by the reliability of service provision. All DHBs achieved a score of 70 or over in *Intervention Services* and *Collaboration* (Appendix G).

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

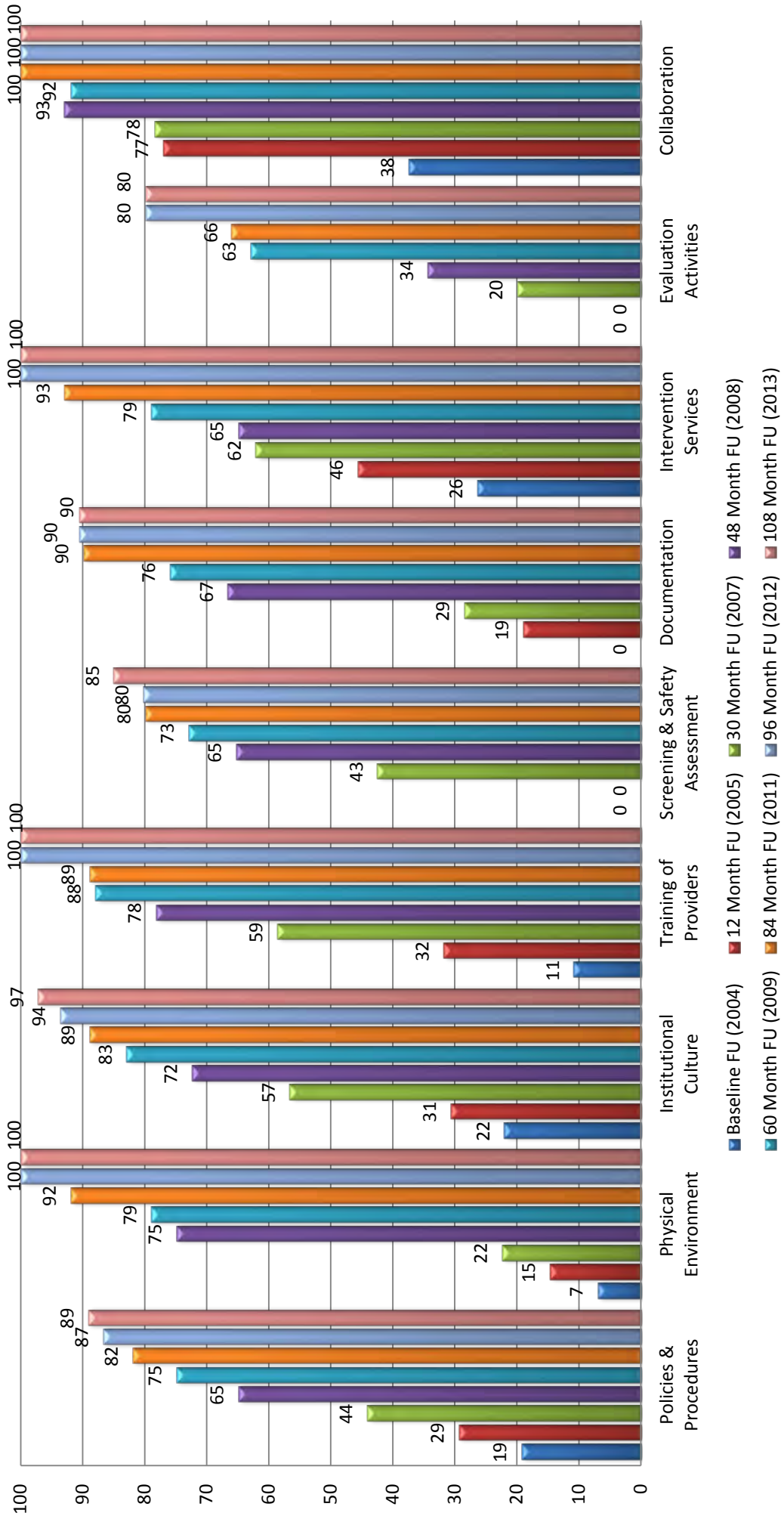


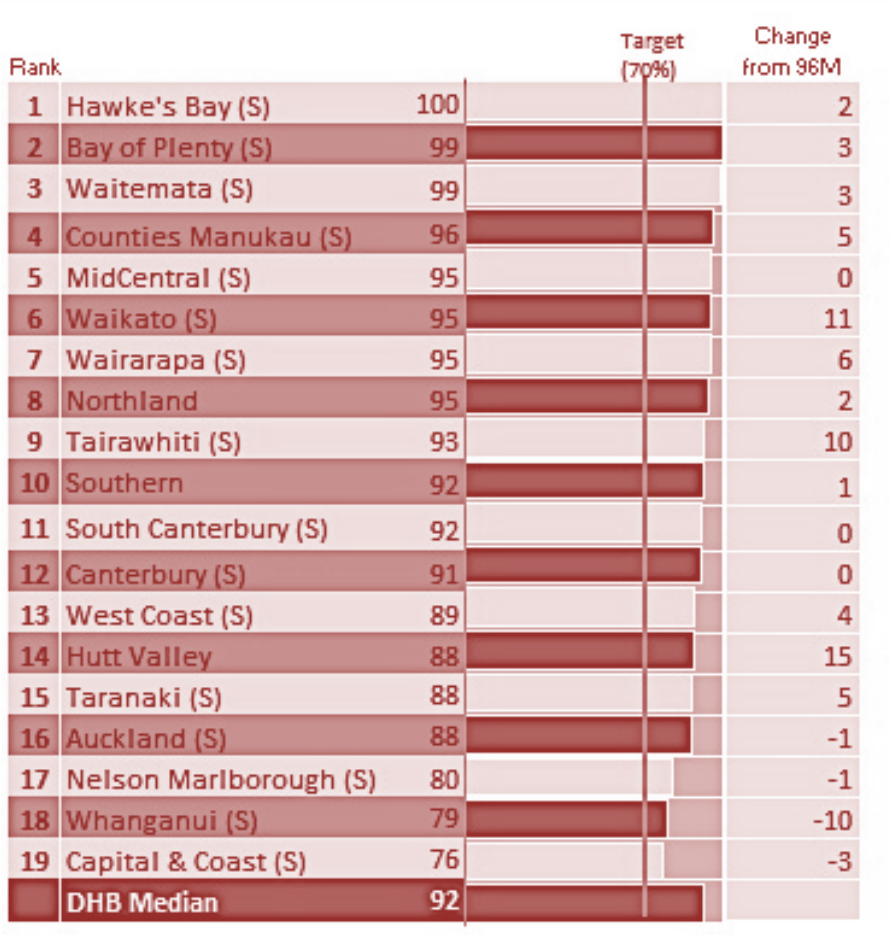

*Figure 11.* Partner Abuse Programme Domain Median Scores

## Partner Abuse Programme League Tables

The development of VIP systems over time is impressive (Figures 5 and 6). The DHB league table for the 108 month follow-up audit is presented in Table 6. The amount of change since the last audit (absolute score difference) ranged from a decrease of 10 to an increase of 15.

Scores in the league table reflect infrastructure development rather than diffusion across or within services. There remains variation in individual DHB scores over time, with some DHBs improving as a result of increased senior leadership, consistency in VIP Coordinator resource and service innovations. DHBs with VIP Coordinator turn over struggle to maintain achievements over time.

*Table 6.* 108 Month Follow-Up Partner Abuse DHB League Table



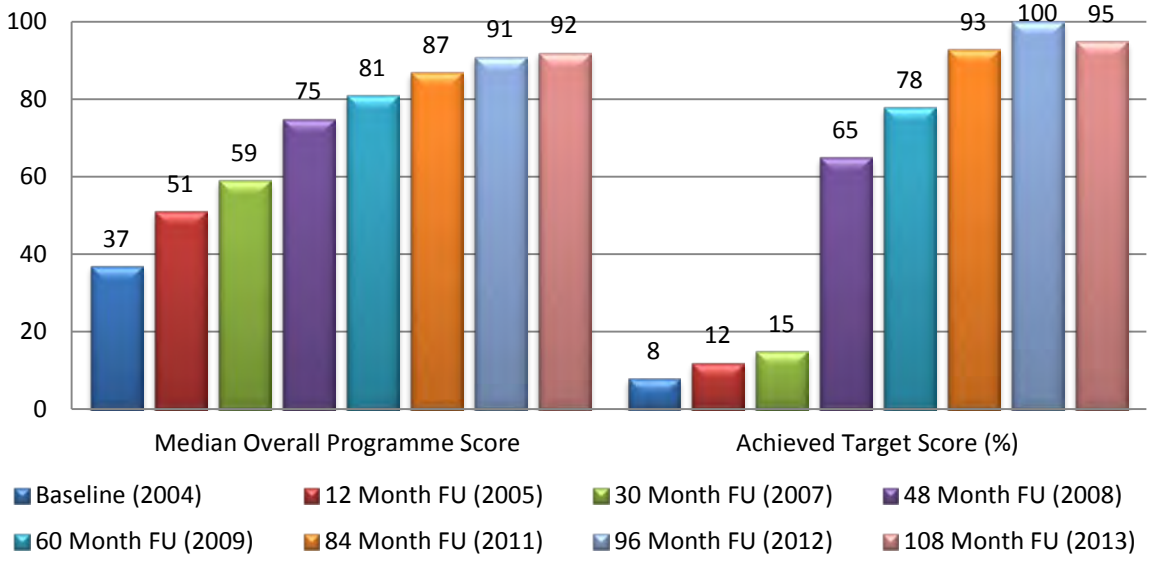
| Rank | | | Target (70%) | Change from 96M |
|---|---|---|---|---|
| 1 | Hawke's Bay (S) | 100 | | 2 |
| 2 | Bay of Plenty (S) | 99 | | 3 |
| 3 | Waitemata (S) | 99 | | 3 |
| 4 | Counties Manukau (S) | 96 | | 5 |
| 5 | MidCentral (S) | 95 | | 0 |
| 6 | Waikato (S) | 95 | | 11 |
| 7 | Wairarapa (S) | 95 | | 6 |
| 8 | Northland | 95 | | 2 |
| 9 | Tairawhiti (S) | 93 | | 10 |
| 10 | Southern | 92 | | 1 |
| 11 | South Canterbury (S) | 92 | | 0 |
| 12 | Canterbury (S) | 91 | | 0 |
| 13 | West Coast (S) | 89 | | 4 |
| 14 | Hutt Valley | 88 | | 15 |
| 15 | Taranaki (S) | 88 | | 5 |
| 16 | Auckland (S) | 88 | | -1 |
| 17 | Nelson Marlborough (S) | 80 | | -1 |
| 18 | Whanganui (S) | 79 | | -10 |
| 19 | Capital & Coast (S) | 76 | | -3 |
| | DHB Median | 92 | | |

Table Notes: (S) Self Audit;
Lakes DHB excluded from League Table due to reforming its VIP in 2013.

## Child Abuse and Neglect Programmes

- *At the 108 month follow-up, the child abuse and neglect intervention programme score ranged from 68 to 100, with 92 as the typical (median) score.*
- *95% of DHBs achieved an overall child abuse and neglect programme score ≥ 70.*

As demonstrated in Figure 12, child abuse and neglect programme scores have increased substantially over time. With programme maturity, the median score increased from 91 at the 96 month follow up audit to 92 at the 108 month follow up. Appendix I provides the data supporting the Figures and Tables in this section.




Note: *Revised CAN Audit Tool* used since 48 month follow up audit (see page 6).

*Figure 12.* Child Abuse and Neglect Programme Scores (2004-2013)

At baseline, child abuse and neglect programme scores were higher compared to partner abuse programme scores (median =37 vs. 20 respectively).

Accompanying higher scores over time has been less score variation (Figure 13). The maximum score variation for child abuse and neglect programmes was at baseline (SD=19.4). Scores at the 84, 96 and 108 month follow-up audits were consistently high, with a few lower scoring outliers.

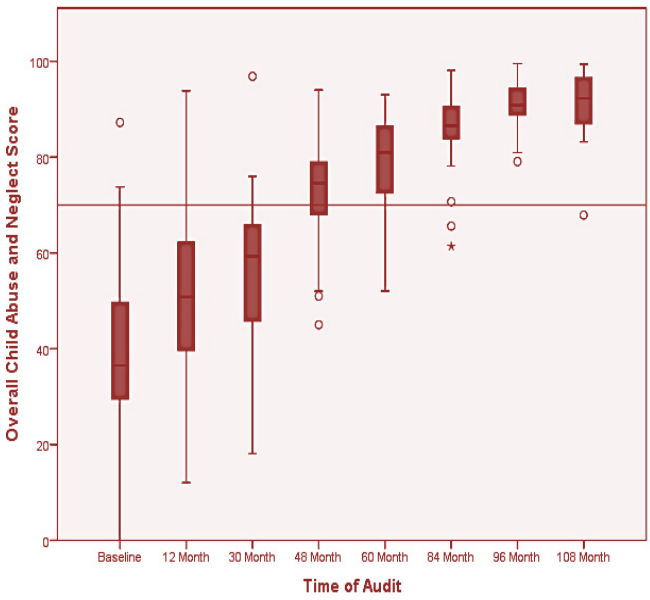



*Figure 13.* DHB Overall Child Abuse and Neglect Score Distributions over Time

## Child Abuse And Neglect Programme Indicators

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

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

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

*95% (n=19) of DHBs include their child abuse and neglect programme in their DHB Quality and Risk programme.*

*DHBs are collaborating with primary health care providers in addressing vulnerable children:*
*95% (n=19) of DHBs include primary health care providers in discharge planning;*
*85% (n=17) of DHBs coordinate referral processes for care transitions between secondary and primary care.*

*70% (n=14) of DHBs record, collate and report on data related to child abuse and neglect assessments, identifications, referrals and alert status to senior management;*
*75% (n=15) of DHBs monitor demographics, risk factors and types of abuse trends.*

*90% (N=18) of DHB emergency departments have a child injury form available to assess indicators that warrant child protection consultation.*

*Across DHBs several versions are in use with varying upper age limits.*

*40% (n=8) of DHBs had established National Child Protection Alert Systems (NCPAS); 45% (n=9) were working to join NCPAS.*

DHBs have achieved significant infrastructure to support a systems approach for responding to child abuse and neglect that includes collaboration with Child, Youth and Family and the Police. Multi-Disciplinary Team (MDT) processes are improving over time as working relationships internal and external to health systems are developed. Health and safety for children are likely to improve as DHBs continue to implement the national Memorandum of Understanding (between Child, Youth and Family, Police and DHBs[36]) and the National Child Protection Alert System (NCPAS[37]).

With system development advancing, there is increasing attention on evaluating service delivery (see page 11). Measuring outputs and outcomes of child protection systems and programmes (including prevention before maltreatment occurs and provision of services once maltreatment is identified) is 'exceedingly challenging' to implement.[38] At a minimum, clear programme goals and definitions are necessary.

## Link with Better Public Service Targets

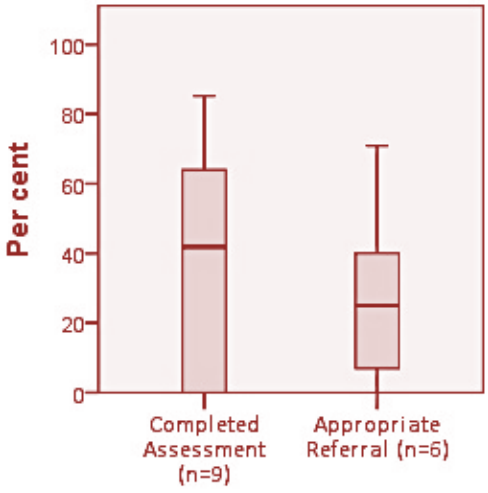
The Better Public Services Targets specifies, "By 2017, we aim to halt the rise in children experiencing physical abuse and reduce current numbers by 5 per cent".[12] This target is based on Child, Youth and Family 'substantiated' cases of physical abuse. For the Violence Intervention Programme, the proportion of children seen in the emergency department with evidence of a child protection assessment and initiation of collaboration with Child, Youth and Family when risk indicators are present are two outputs of interest. Of note, the National Child Protection Alert System will also have a monitoring and evaluation process specified.

To assist standardisation of data collection, the *Quality Improvement Toolkit* includes an Excel file for *Child Abuse & Neglect Injury Assessment Clinical Audit Tool* and a *Child, Youth and Family Referral Clinical Audit Tool.* DHB self reported clinical audit data are presented in the following sections. As was the case for partner abuse monitoring, child protection data collection frequency and quality remains variable. The summary data provided in the following sections are indicative only. Further standardisation of data collection is needed to provide robust information to inform policy and practice.

## Clinical Audit: Injury Assessment of Children Presenting to the Emergency Department

A protocol of standardised assessment to rule out child protection risks raises awareness of child abuse and neglect and increases the number of cases identified as requiring consultation for suspected abuse.[39-41] Although there is debate about individual indicators, and the predictive value of a positive standardised assessment is unknown, Sittig and colleagues summarise that, "Professionals are urged to be explicitly aware of child abuse as one of the differential diagnoses".[42] Ninety per cent (n=18) of DHBs reported they utilised a standardised child injury assessment documentation form ('injury flow charts'). The age group to which the child injury flow chart is applied, however, ranges across DHBs, from children under 2 years of age to under 18 years of age. In some instances, the child protection chart is applied to all children under two years of age, based on age of highest risk for child maltreatment.

Sixty per cent (n=12) of DHBs reported reviewing Emergency Department child records for completed injury flow charts. The number of eligible child injury clinical records reviewed ranged from 10 to 62 records over an audit period that ranged from 5 days to 1 year. DHBs provided additional information about the proportion of reviewed records that included the injury assessment (n=9, 45%) and appropriate referrals (n=6, 33%) (Figure 14). The following data reflects accountability monitoring for child injury assessment documentation. It does not reflect the actual number of children identified to be at risk or the number of children referred to Child, Youth and Family.




Among nine DHBs providing review data, the proportion of completed child injury assessments ranged from 0% to 85% (median = 42%).

Among six DHBs providing data, the proportion with documentation of appropriate referral (based on assessment findings) ranged from 0% to 71% (median = 24%).

*Figure 14.* Child Protection Assessment of Children Presenting to Emergency Departments

## Clinical Audit: Report of Concern Referrals made by DHBs to Child, Youth & Family

Multi-agency collaboration is essential in preventing harm to children.[36,43] All DHBs have policies for reporting child protection concerns to Child, Youth and Family. The Memorandum of Understanding between Child, Youth and Family, New Zealand Police and District Health Boards outlines agency responsibilities, and Schedule 2 references the Child, Youth and Family DHB Liaison Social Worker resource.[36] Clinical audit of documentation supporting DHB referrals to Child, Youth and Family is one measure of Violence Intervention Programme accountability.

Sixty per cent (n=12) of DHBs reported conducting review of clinical records involving Reports of Concern made to Child, Youth and Family. The period of review varied from 1 month to one year and the number of Reports of Concern made during the audit period varied from 6 to 596. Ten of the 12 DHBs provided internal clinical audit data in their 108 month follow-up evaluation (Figure 15 and Table 7).

Among Reports of Concern made during the audit period, clinical audits were conducted for between 2% and 100% (median = 62%). This equates to between 4 and 62 charts reviewed. Typically, partner abuse assessment was documented 50% of the time, child maltreatment was included in the medical diagnoses 34% of the time, and child protection concerns included in the Discharge Summary 20% of the time.

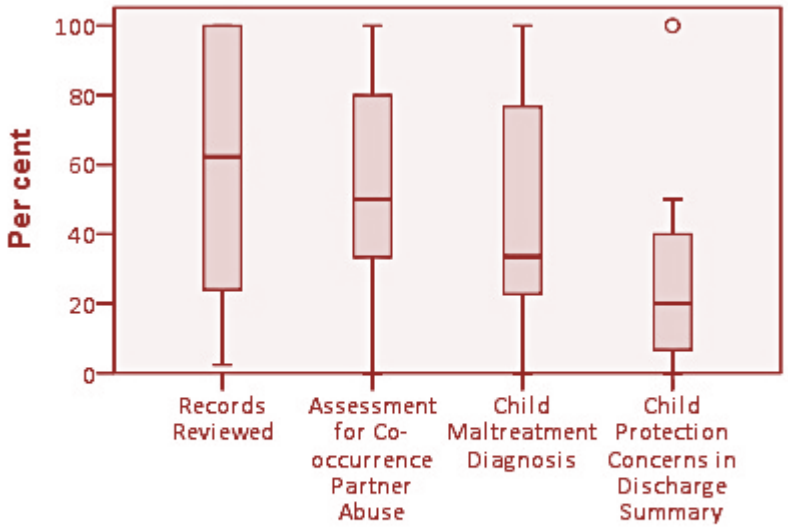



*Figure 15.* DHB Review of Child, Youth and Family Report of Concern Referrals

*Table 7*. Clinical Audit Related to Child, Youth and Family Reports of Concern

| | No. of DHBs | Proportion Range | Proportion Median |
|---|---|---|---|
| Reports of Concern health records reviewed | 10 | 2 - 100% | 62% |
| Co-occurrence of Partner Abuse assessed | 9 | 0 - 100% | 50% |
| Child maltreatment included in diagnoses | 8 | 0 - 100% | 34% |
| Child protection concerns included in Discharge Summary | 9 | 0 - 100% | 20% |

## Child Abuse & Neglect Programme Domains[a]

All nine child abuse and neglect programme median domain scores remained stable between the 96 and 108 month follow-up audits; all nine domain scores exceeded 70 for the third consecutive audit (Figure 16). *Evaluation Activities* was the least developed domain; 9 DHBs had yet to achieve a score of 70 for *Evaluation Activities* (see Appendix G).

## Child Abuse and Neglect Programme League Tables

The development of the VIP child abuse and neglect system over time is impressive (Figures 12 and 13). The DHB league table for the 108 month follow-up audit is presented in Table 8. The amount of change since the last audit (absolute score difference) ranged from a decrease of 7 to an increase of 10.

Scores in the league table reflect infrastructure development not VIP diffusion across or within services. There remains variation in individual DHB scores over time, with some DHBs improving as a result of increased senior leadership, consistency in VIP Coordinator resource and service innovations. As noted in the partner abuse section, DHBs with VIP Coordinator turn over struggle to maintain achievements over time.

*Table 8. 108* Month Follow-Up Child Abuse and Neglect DHB League Table

| Rank | | | Target (70%) | Change from 96M |
|---|---|---|---|---|
| 1 | Waitemata (S) | 100 | | 0 |
| 2 | Hawke's Bay (S) | 99 | | 3 |
| 3 | Auckland (S) | 98 | | -1 |
| 4 | Counties Manukau (S) | 98 | | 7 |
| 5 | Wairarapa (S) | 97 | | 2 |
| 6 | Bay of Plenty (S) | 96 | | 2 |
| 7 | South Canterbury (S) | 96 | | 5 |
| 8 | Canterbury (S) | 94 | | 0 |
| 9 | MidCentral (S) | 93 | | 1 |
| 10 | Southern | 92 | | 1 |
| 11 | Waikato (S) | 92 | | 3 |
| 12 | Taranaki (S) | 91 | | 5 |
| 13 | Tairawhiti (S) | 91 | | 10 |
| 14 | Capital & Coast (S) | 87 | | -2 |
| 15 | Hutt Valley | 87 | | 8 |
| 16 | Northland | 87 | | -2 |
| 17 | Whanganui (S) | 85 | | -1 |
| 18 | West Coast (S) | 85 | | -4 |
| 19 | Nelson Marlborough (S) | 83 | | -7 |
| | DHB Median | 92 | | |

Table notes: (S) Self Audit;
Lakes DHB excluded due to reforming its VIP in 2013.

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

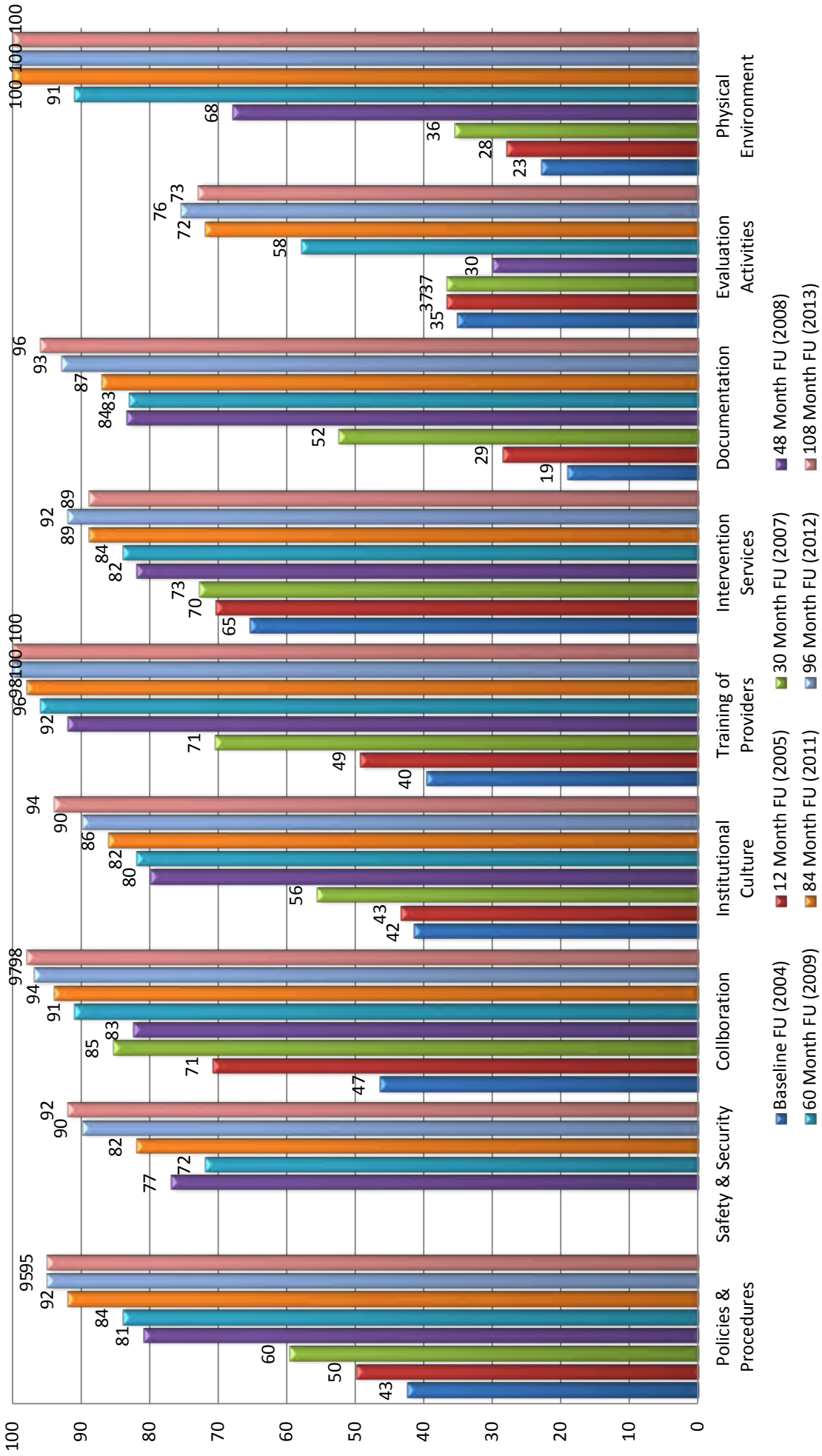



*Figure 16.* Child Abuse and Neglect Programme Domain Median Scores

Note: The Revised Child Abuse & Neglect audit tool, with the new *Safety & Security* domain, was implemented beginning with the 48 month follow up audit.

## Cultural Responsiveness and Whānau Ora

- *DHB 108 Month follow-up Partner Abuse programme cultural responsiveness scores ranged from 53 to 100, with 95 as the median.*
- *DHB 108 Month follow-up Child Abuse and Neglect programme cultural responsiveness scores ranged from 75 to 100, with 91 as the median.*

VIP recognises culturally responsive health systems contribute to reducing health inequalities. The following Figure (Figure 17) summarises the sub-set of audit tool indicators evaluating cultural responsiveness within VIP programmes across the eight evaluation periods. Cultural responsiveness scores continue to increase over time.

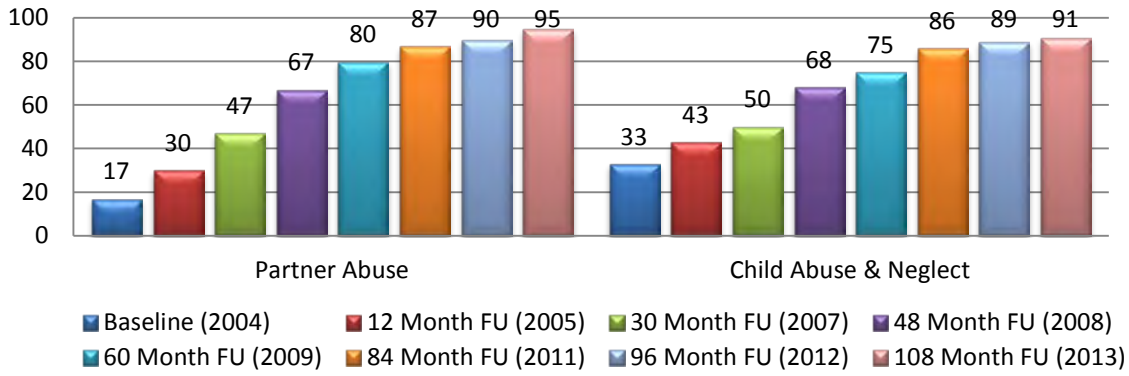



*Figure 17.* Median Hospital VIP Cultural Responsiveness Scores 2004-2012 (n=27 hospitals); 2013 (n=20 DHBs).

Despite advances, further development is needed. There exists variation across DHBs and some indicators continue to under-achieve (Figure 18). For example, only nine (45%) of the twenty DHBs evaluated whether VIP services are effective for Māori.

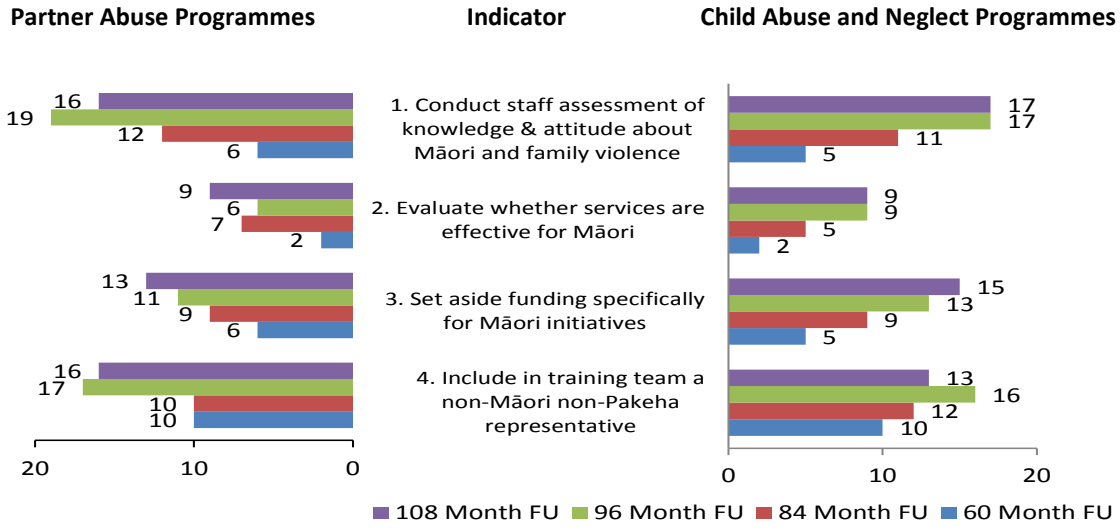



*Figure* 18. Selected Cultural Responsiveness Indicators (N=20 DHBs)

## Transition To Self Audit

This is the third audit round in which DHB VIPs submitted self audit data based on Excel file partner abuse and child abuse and neglect audit tools. In importing and checking calculations in SPSS, some errors were noted and subsequently corrected. A known file calculation error for several cultural indicators in the CAN tool (if user selects 'YES' and then 'NO', the score does not return to zero) was routinely checked and corrected. A full quality check of submitted self audits, however, was not conducted. Likely explanations for errors continue to involve either missing data or over-riding or not enabling the Excel file macro function. Training in the Delphi Tools is currently included in FVIC orientation package.

In 4 selected DHBS, external audits were conducted in addition to the self audit. The overall mean self and external audit score differences (self audit minus external audit score) were -0.3 and 2.4 for partner abuse and child abuse and neglect respectively. While the average difference is minimal, there were four instances of domain score differences greater than ± 4 (Table 9). Child Abuse and Neglect *Documentation* and *Evaluation Activities* domains tended to be over-estimated; partner abuse *Training* and *Intervention Services* domains tended to be under-estimated.

*Table 9*. Differences between domain self and external audit scores (n=10).

| Programme | Domain | Mean Difference (self minus external audit) |
|---|---|---|
| Child abuse and neglect | Documentation | 10.5 |
| | Evaluation Activities | 8.5 |
| Partner abuse | Training of Providers | -8.5 |
| | Intervention Services | -13 |

## PROGRAMME IMPLICATIONS

The 108 month Violence Intervention Programme follow-up audit findings contain evidence to guide further development at the national, regional and local levels. As VIP infrastructure within DHBs reaches maturity, the focus turns to: (1) improved reliability and quality of services delivered to vulnerable women and children, (2) improved accountability data, (3) programme sustainability. While significant progress has been made, there remains variation in reporting accountability data as well as internal quality improvement processes. Ongoing workforce development, additional resources, clearer standards and technical support are all needed to help DHBs move from testing improvements to implementation and sustaining achievements.

The need for workforce development to address a gap in quality monitoring skills and knowledge was identified in 2012. In collaboration with Ko Awatea, five regional Model for Improvement workshops were convened for DHB VIP personnel in 2013. Subsequent to the workshop, nine DHBs submitted draft rapid improvement cycles (plan-do-study-act) for feedback.

Review of internal audit data indicated that there is significant variation from the VIP QI Toolkit guidelines for internal audit. Several issues are noted below:

- The time period for selecting records to review was variable from 1 day to 12 months.
- The number of eligible records reviewed was often less than the number recommended in the Toolkit.

- Data provided was typically the most recent audit, while in other instances data had been merged across two or more audits.
- There is no allowance for reporting variation in screening rates across hospitals within a DHB.
- The patient population (census) of various services is unknown.
- The proportion of personnel in a service who have completed VIP training is known in a limited number of DHBs.
- For partner violence, the definition of 'eligible' and 'screened' is variable. For example, in some locations screening documentation is considered 'achieved' when 'not screened' is documented. And, disclosure data were rarely provided.
- Completion of accountability data was variably reported as numbers or per cents, with missing data sometimes prohibiting calculation of rates.
- The applicable age for completion of child injury flow charts is not standardised, ranging from under 2 to under 18 years of age. Eligibility also varies, from only children with injuries, to all children under 2 years of age.

These issues highlight the need for supporting more rigorous and consistent internal audit processes to inform improving service delivery quality. The burden of manual chart review across services over time is acknowledged as a barrier. The development of clear definitions, electronic data systems and technical support in improvement processes are needed.

In 2014, **infrastructure monitoring** will continue to assess sustainability of system indicators.
All DHBs will submit a self audit with data collated by external evaluators. External evaluators will also provide comment on self audit documents. External audits (including site visits) will be conducted in four selected DHBs in 2014.

In 2014, **internal quality monitoring** processes will be reviewed. The National VIP Team will support standardised methods, data reliability and quality improvement action cycles. Standardised 'snapshot' data of selected indicators in selected services will be collated nationally in 2014 and 2015.

## VIP PRIORITIES FOR 2014-2015

Evaluation activities will support VIP priorities for 2014 to 2015. These priorities include:

- Improving identification, assessment and responses to vulnerable children and their families and whānau.
- Improving service delivery for women, children and whānau experiencing family violence evidenced by quality improvement data.
- Supporting integration and coordination of safety planning for vulnerable families across primary, community and acute health services.
- Contributing to better coordination across health and social services and better outcomes for vulnerable children and their families and whānau (Children's Action Plan, 2012).[11]
- Supporting government priority to reduce assaults on children by 2017 (Better Public Services Key Result Action Area, 2013).[12]
- Increasing the number of DHBs that have implemented National Child Protection Alert Systems.
- Supporting DHB implementation of Shaken Baby Prevention Programmes.
- Further develop activities that improve VIP responsiveness to Māori.
- Supporting DHB implementation of elder abuse and neglect programmes.

## Strengths and Limitations

Strengths of this evaluation project include using established family violence programme evaluation instruments[16,18,19] and following standard quality improvement processes in auditing.[44,45] The project promotes a comprehensive systems approach to addressing family violence, a key characteristic for delivering effective services.[2,18,21,23]

*During 2013 all DHBs participated in quality improvement training in the IHI Model for Improvement (including rapid improvement cycles).*

Our processes of audit planning, site visits and reporting facilitate DHB VIP programme development over time. The evaluation project is also integrated in the VIP management programme, providing the Ministry the ability to target remedial actions in the context of limited resources. The 96 month follow-up audit indicated the need for FVIC workforce development in quality improvement. During 2013, all DHBs participated in quality improvement training in the IHI Model for Improvement[34] (including rapid improvement cycles). Prior initiatives included the *VIP Quality Improvement Toolkit* and financial and technical support for DHB Whānau Ora initiatives. The repeated audit rounds also foster a sense of urgency,[46] supporting timely policy revisions, procedure endorsements and filling of FVIC positions. Finally, and perhaps most importantly, the longitudinal nature of the evaluation has allowed monitoring of change over time (2004 to 2013).

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

- By design, this study is limited to DHBs providing acute hospital and community services at secondary and tertiary public hospitals. The VIP does not include services provided by private hospitals which may also provide publicly funded services, or primary care where family violence prevention programmes are being introduced opportunistically in DHB regions.
- Audit tool scores range from 0 to 100. This means that as programmes mature they approach the top end of the scale and have little room for score improvement, creating a 'ceiling effect'.
- As the VIP programme has evolved, some indicators become 'out of date', such as the partner abuse programme tool requiring monthly (rather than quarterly) governance (steering group) meetings. While we might have altered the tool over time, we chose to hold the tool constant for the sake of comparisons over time.
- Finally, the VIP audit does not include indicators related to the *Family Violence Intervention Guidelines: Elder Abuse and Neglect*,[47] although an increasing number of DHBs have endorsed policies addressing elder abuse and neglect assessment and intervention (n=13 DHBs, 65%).

## Conclusions

New Zealand DHBs have continued to make significant progress in developing systems for responding to women and children at risk for ongoing exposure to family violence. Ninety-five per cent of DHBs have achieved the benchmark target score in both their partner abuse and child abuse and neglect programmes as at 30 June 2013. Established programme components include policies and procedures, leadership and governance and collaboration with local government and non-government specialist family violence services. Standardised one day training programmes for clinical staff are supported by service level clinical champions and Family Violence Intervention Coordinators. While programmes are doing well overall, there remains significant gaps.

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

Implementation of the Ministry's Family Violence Intervention Guidelines: Child and Partner Abuse[5] (*The Guidelines*) across target services is still in progress. Many DHBs have yet to roll out their VIP to all targeted services. For those implementing *The Guidelines,* increasing service delivery reliability and quality continues to present challenges. Leadership, coordination, quality monitoring and evaluation activities are all elements required to enhance programme integration and inter-sectoral collaboration. On-going workforce development support for applying the Model for Improvement and learning from high performing services are recommended.

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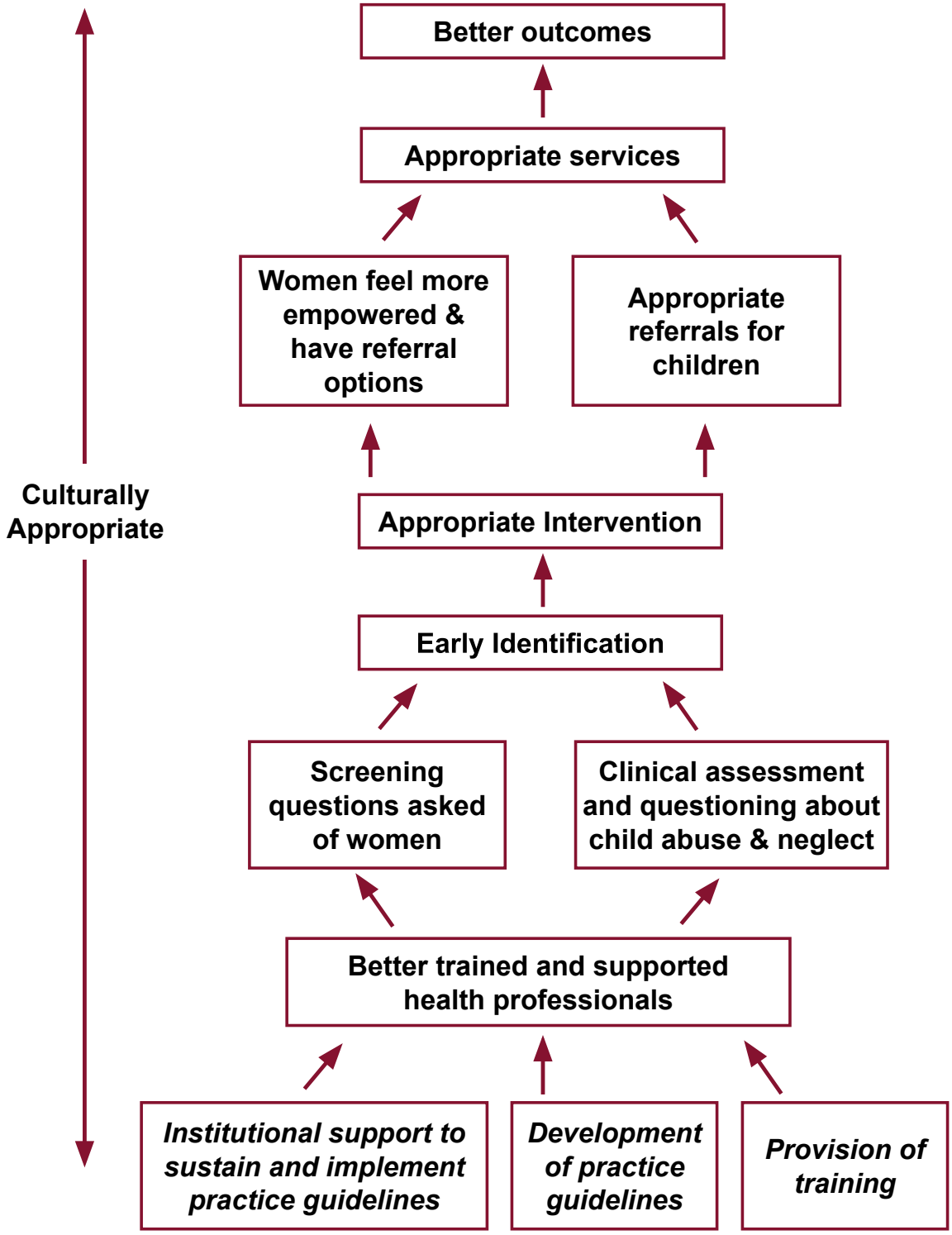
# APPENDICES

## APPENDIX A: Family Violence Project Programme Logic[4]




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

## APPENDIX B: District Health Board Hospitals

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

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

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

## APPENDIX C: DHB Programme Information Form

### Violence Intervention Programme Evaluation
108 Month Follow-up Audit

***Programme Information Form***

### DHB Information:

*Please complete:*

**DHB:**

Hospital(s):

Self Audit Due Date:

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

*Please enter relevant name, position, and department:*

DHB CEO:

DHB Funding & Planning Manager:

DHB VIP Sponsor (person with VIP signing authority):

**DHB Audit contact details:**

Name:

Title:

Phone/Mobile:

E-Mail:

**1. Coordinator Status**

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

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

**2. Additional VIP Support Positions**

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

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

**3. Whānau Ora**

**3a. Please list VIP Whānau Ora actions taken since the last audit.**

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

**3b. Does your VIP strategic plan identify actions that you will take to improve cultural responsiveness to Māori and to contribute to Whānau Ora workforce development?**

| *Please elaborate:* | YES/NO *(Delete one)* |
|---|---|
| | |

**4. National Training Package**

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

**5. Elder Abuse**

| | |
|---|---|
| Does the DHB have policies on Older Adult/Elder Abuse and Neglect? | YES/NO *(Delete one)* |
| *Title:*<br>*Date of Endorsement:* | |

**6. Disability**

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

**7. Status Change**

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

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

| Service (note whether hospital in patient or community out patient service) | VIP Implementation[5] (tick YES or NO for each service) | | % staff trained in service area[6] | Partner Abuse Screening Audit (enter data for most recent audit) *Refer to QIA Toolkit: VIP Partner Abuse Screening and Documentation Clinical Audit Tool* | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Review Period Start | Review Period End | No. Eligible Records Reviewed | No. Screened | No. Disclosed | Comments |
| | YES | NO | | dd/mm/yy | dd/mm/yy | | | | |
| Emergency Department | | | | | | | | | |
| Child Health – In Patient | | | | | | | | | |
| Child Health – Community | | | | | | | | | |
| Child Health – Other: | | | | | | | | | |
| Maternity - In Patient | | | | | | | | | |
| Maternity – Community | | | | | | | | | |
| Sexual Health – Community | | | | | | | | | |
| Mental Health – In Patient | | | | | | | | | |
| Mental Health – Community | | | | | | | | | |
| Alcohol & Drug – Community | | | | | | | | | |
| *Other (e.g., EAN, Primary Care, other Family/Whanau health services):* | | | | | | | | | |
| *Other:* | | | | | | | | | |

[5] Child Abuse and Neglect and Partner Abuse assessment and intervention.
[6] Refers to clinical staff who are responsible for implementing programme in a given service (e.g., nurse) as reported to National Trainer

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

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

| | Review Period Start (dd/mm/yy) | Review Period End (dd/mm/yy) | No. Eligible Records Reviewed | No. Injury flow chart in notes | No. with appropriate referral (both discussion and plan documented) | Comments |
|---|---|---|---|---|---|---|
| Emergency Department | | | | | | |

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

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

**11. National Child Protection Alert participation status**

| Sign Off Date | Comments |
|---|---|
| | |

**12. VIP strategic planning documents**

| | Title (time period) | Sign Off Date | Comments |
|---|---|---|---|
| **VIP Strategic Plan** | | | |
| **VIP Training Action Plan** | | | |
| **VIP Quality Improvement Action Plan** | | | |
| **VIP Whānau Ora Plan** | | | |
| **Other DHB VIP Plan** | | | |

**13. Most significant VIP achievements since the last audit:**

**14. Programme Strengths:**

**15. Recommendations for programme improvement:**

**16. Any other comments?**

## APPENDIX D: Delphi Scoring Weights

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

The weightings used for this study are provided below.

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

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

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

# APPENDIX E: 2012-2013 Audit Round Process

*[Letterhead removed]*

**VIP AUDIT PREPARATION INFORMATION**
**Self and External Audits**
*108 Month Follow-Up Evaluation, 2012-2013*

The VIP evaluation provides the opportunity for DHBs to build competence in family violence service delivery as well as measure progress over time. Processes are guided by a philosophy of supporting programme leaders in building a culture of improvement. External audit participation requires access only to DHB and hospital system-level information and materials. No patient data is required. The evaluation project is approved by the Multi-region Ethics Committee (AKY/03/09/218 with current approval to 5 December 2013).

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

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

- Self Audit Preparation notes
- Self Audit Plan Example
- Physical Environment Walk Through Form

Preparation should build on previous audit documentation, updating and improving evidence collation. If required, blank partner abuse and child abuse and neglect audit files are available to download at www.aut.ac.nz/vipevaluation.

**Submitting Your Self Audit**
Complete the following items:

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

Please double-check all items have been answered and submit the above items to Christine McLean by your due date.

Self audit indicator evidence:

- There should be evidence of all achieved indicators.
- Collate indicator evidence and have available.
- Reference evidence location (such as policy title, date and page number) in the respective 'evidence' columns of the excel audit tools

**External Audit Preparation** (one day on-site visit)

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

**Reporting**

**Self Audit Report**. You are not required to submit this report to AUT if you are also having an external audit.

**External Audit Report.**

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

**National Report.** A national report and summary documenting VIP programme development across the audit periods will be made available in July 2013. **Confidentiality:** Audit discussions and individual DHB reports provided by auditors will be kept confidential between the DHB and MOH VIP team. **National reports of overall programme and cultural responsiveness scores, however, will identify DHBs (e.g., in league tables).**

**Audit Support**
Audit support is available through various means. Regional FVICs may be the first point of contact. FVIC, particularly those new to the role, are encouraged to discuss audit preparation with Annette Goodwin: AUT Administrator (agoodwin@aut.ac.nz) in the first Instance, or Christine McLean with queries about the audit tool or process. The Ministry of Health contact person is Sue Zimmerman. Please feel free to contact her in regards to the study on (09) 580 9145 or **Sue_Zimmerman@moh.govt.nz.**

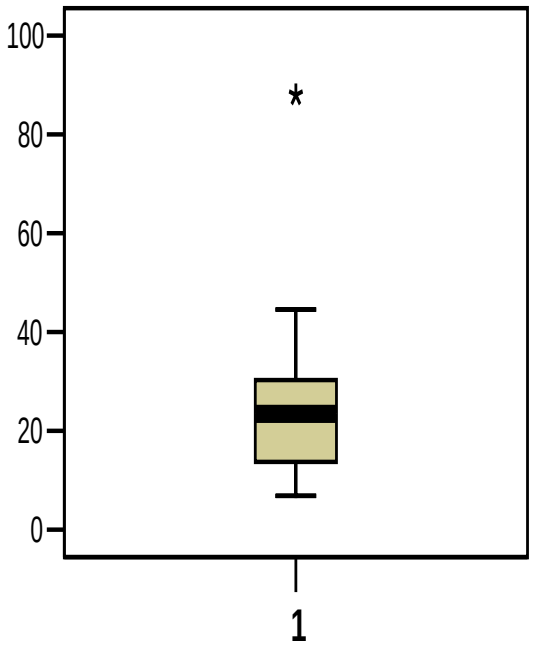
**Concerns:** For concerns regarding the process or conduct of the audit please contact Jane Koziol-McLain or Sue Zimmerman.

**Research Team:**

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


| | |
|---|---|
| Christine McLean<br>Research Project Manager<br>Interdisciplinary Trauma Research Centre<br>School of Healthcare Practice<br>Auckland University of Technology<br>(09) 921 9999 X 7114 cmclean@aut.ac.nz | Professor Jane Koziol-McLain, PhD, RN<br>Principal Investigator<br>Interdisciplinary Trauma Research Centre<br>School of Healthcare Practice<br>Auckland University of Technology<br>(09) 921 9670 jkoziolm@aut.ac.nz |

## APPENDIX F: How to Interpret Box Plots




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

(SPSS)

## APPENDIX G. Partner Abuse Baseline and Follow-Up Scores

| | Median Scores | | | | | | | | Achieving Target Score (≥70) n (%) | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *B* | $F_{12}$ | $F_{30}$ | $F_{48}$ | $F_{60}$ | $F_{84}$ | $F_{96}$[c] | $F_{108}$[d] | *B* | $F_{12}$ | $F_{30}$[b] | $F_{48}$ | $F_{60}$ | $F_{84}$ | $F_{96}$[c] | $F_{108}$[d]/20 |
| **Overall Score** | 19.6 | 27.6 | 49.2 | 66.9 | 74.4 | 84.4 | 91.3 | **92** | 1 (4%) | 2 (8%) | 5 (19%) | 13[a] (48%) | 15 (56%) | 25 (93%) | 27 (100%) | **19 (95%)** |
| **Domain Scores** | | | | | | | | | | | | | | | | |
| Policies and Procedures | 19.4 | 29.5 | 48.8 | 62.0 | 75.1 | 82.1 | 86.8 | **89.15** | 1 (4%) | 2 (8%) | 7 (26%) | 11 (41%) | 16 (59%) | 20 (74%) | 24 (89%) | **18 (90%)** |
| Physical Environment | 7.1 | 14.7 | 23.1 | 75.0 | 78.8 | 91.3 | 100 | **100** | 0 (0%) | 1 (4%) | 4 (15%) | 16 (59%) | 16 (59%) | 23 (85%) | 25 (93%) | **18 (90%)** |
| Institutional Culture | 22.1 | 30.7 | 59.0 | 72.4 | 83.4 | 88.9 | 93.7 | **97.24** | 2 (8%) | 5 (20%) | 8 (30%) | 15 (56%) | 16 (59%) | 23 (85%) | 25 (93%) | **18 (90%)** |
| Training of Providers | 10.9 | 31.9 | 58.7 | 78.2 | 88.4 | 89.1 | 100 | **100** | 1 (4%) | 5 (20%) | 8 (30%) | 15 (56%) | 18 (67%) | 26 (96%) | 26 (96%) | **19 (95%)** |
| Screening and Safety Assessment | 0.0 | 0.0 | 42.5 | 65.3 | 73.2 | 80.3 | 80.3 | **85.04** | 1 (4%) | 2 (8%) | 5 (19%) | 13 (48%) | 15 (56%) | 18 (67%) | 22 (82%) | **17 (85%)** |
| Documentation | 0.0 | 19.1 | 28.6 | 66.6 | 76.1 | 90.4 | 90.5 | **90.48** | 0 (0%) | 0 (0%) | 2 (7%) | 12 (44%) | 14 (52%) | 22 (82%) | 24 (89%) | **18 (90%)** |
| Intervention Services | 26.4 | 45.7 | 62.1 | 65.0 | 79.2 | 92.8 | 100 | **100** | 4 (16%) | 6 (24%) | 9 (33%) | 11 (41%) | 17 (63%) | 24 (89%) | 27 (100%) | **20 (100%)** |
| Evaluation Activities | 0.0 | 0.0 | 20.0 | 34.4 | 63.2 | 66.4 | 80.0 | **80.00** | 1 (4%) | 1 (4%) | 4 (15%) | 6 (22%) | 11 (41%) | 13 (48%) | 23 (85%) | **14 (70%)** |
| Collaboration | 37.5 | 77.1 | 78.5 | 93.0 | 91.6 | 100.0 | 100 | **100** | 1 (4%) | 15 (60%) | 19 (70%) | 23 (85%) | 25 (93%) | 27 (100%) | 27 (100%) | **20 (100%)** |

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

## APPENDIX H: Partner Abuse Delphi Item Analysis

Note: 108 month follow-up scores include self audit scores (n=16 DHBs) and external audit scores (n=4 DHBs). Note: The 96 month follow-up scores were hospital based including self audit scores (n=14 hospitals) and external audit scores (n=13 DHBs).

| | "YES" responses | 84 mo FU Hospitals (%) | 96 mo FU Hospitals (%) | 108 mo FU DHBs (%) |
|---|---|---|---|---|
| **CATEGORY 1. POLICIES AND PROCEDURES** | | | | |
| 1.1 | Are there official, written hospital policies regarding the assessment and treatment of victims of partner abuse? If yes, do policies: | 26 (96%) | **27 (100%)** | **19 (95%)** |
| | a) define partner abuse? | 26 (96%) | **27 (100%)** | **20 (100%)** |
| | b) mandate training on partner abuse for any staff? | 26 (96%) | **27 (100%)** | **20 (100%)** |
| | c) advocate universal screening for women anywhere in the hospital? | 26 (96%) | **27 (100%)** | **20 (100%)** |
| | d) define who is responsible for screening? | 26 (96%) | **27 (100%)** | **20 (100%)** |
| | e) address documentation? | 26 (96%) | **27 (100%)** | **19 (95%)** |
| | f) address referral of victims? | 26 (96%) | **27 (100%)** | **20 (100%)** |
| | g) address legal reporting requirements? | 26 (96%) | **26 (96%)** | **19 (95%)** |
| | h) address the responsibilities to, and needs of, Māori? | 26 (96%) | **27 (100%)** | **20 (100%)** |
| | i) address the needs of other (non-Māori/non-Pakeha) cultural and/or ethnic groups? | 26 (96%) | **25 (93%)** | **19 (95%)** |
| | j) address the needs of LGBT clients? | 19 (70%) | **24 (89%)** | **19 (95%)** |
| 1.2 | Is there evidence of a hospital-based partner abuse working group? If yes, does the group: | 27 (100%) | **27 (100%)** | **20 (100%)** |
| | a) meet at least every month? | 8 (30%) | **11 (41%)** | **11 (55%)** |
| | b) include representative(s) from more than two departments? | 27 (100%) | **27 (100%)** | **20 (100%)** |
| | c) include representative(s) from the security department? | 18 (67%) | **21 (78%)** | **15 (75%)** |
| | d) include physician(s) from the medical staff? | 24 (89%) | **26 (96%)** | **17 (85%)** |
| | e) include representative(s) from a partner abuse advocacy organization (eg., Women's Refuge)? | 25 (93%) | **25 (93%)** | **18 (90%)** |
| | f) include representative(s) from hospital administration? | 27 (100%) | **27 (100%)** | **20 (100%)** |
| | g) include Māori representative(s)? | 27 (100%) | **27 (100%)** | **20 (100%)** |
| 1.3 | Does the hospital provide direct financial support for the partner abuse programme (beyond VIP funding)? | 22 (81%) | **21 (78%)** | **17 (85%)** |
| $1.3_a$ | Is funding set aside specifically for Māori programmes and initiatives? | 13 (48%) | **15 (56%)** | **13 (65%)** |
| 1.4 | Is there a mandatory universal screening policy in place? | 26 (96%) | **27 (100%)** | **20 (100%)** |

| | "YES" responses | 84 mo FU Hospitals (%) | 96 mo FU Hospitals (%) | 108 mo FU DHBs (%) |
|---|---|---|---|---|
| 1.5 | Are there quality assurance procedures in place to ensure partner abuse screening? | 23 (85%) | **27 (100%)** | **19 (95%)** |
| | a) regular chart audits to assess screening? | 23 (85%) | 26 (96%) | **18 (90%)** |
| | b) positive reinforcers to promote screening? | 22 (82%) | 25 (93%) | **16 (80%)** |
| | c) is there regular supervision? | 12 (44%) | 24 (89%) | **18 (90%** |
| 1.6 | Are there procedures for security measures to be taken when victims of partner abuse are identified? If yes, | | | |
| | a) written procedures that outline the security department's role in working with victims and perpetrators? | 12 (44%) | 18 (67%) | **17 (85%)** |
| | b) procedures that include name/phone block for victims admitted to hospital? | 20 (74%) | 21 (78%) | **17 (85%)** |
| | c) procedures that include provisions for safe transport from the hospital to shelter? | 17 (63%) | 23 (85%) | **17 (85%)** |
| | d) do these procedures take into account the needs of Māori? | 13 (48%) | 14 (52%) | **15 (75%)** |
| 1.7 | Is there an identifiable partner abuse coordinator at the hospital? If yes is it a: (*choose one*) | 27 (100%) | 27 (100%) | **20 (100%)** |
| | a) part time position or included with other responsibilities? | 13 (48%) | 8 (30%) | **6 (30%)** |
| | b) full-time position with no other responsibilities? | 14 (52%) | 19 (70%) | **14 (70%)** |
| **CATEGORY 2. PHYSICAL ENVIRONMENT** | | | | |
| 2.1 | In how many locations are posters/brochures related to partner abuse on display in the hospital? (up to 35): | | | |
| | 11-20 | 1 (4%) | 3 (11%) | **2 (10%)** |
| | 21-35 | 26 (96%) | 24 (89%) | **18 (90%)** |
| | In how many locations are there Māori images related to partner abuse on display? (up to 17): | | | |
| | 1-10 | 1 (4%) | 0 (0%) | **0 (0%)** |
| | 11-17 | 26 (96%) | 27 (100%) | **20 (100%)** |
| 2.2 | In how many locations is there referral information related to partner abuse services on display in the hospital? (Can be included on the posters/brochure noted above)(up to 35): | | | |
| | 11-20 | 3 (11%) | 3 (11%) | **2 (10%)** |
| | 21-35 | 23 (85%) | 24 (89%) | **18 (90%)** |
| | In how many locations is there referral information related to Māori providers of partner abuse services on public display in the hospital? (up to 17): | | | |
| | 0-10 | 4 (15%) | 1 (4%) | **3 (15%)** |
| | 11-17 | 23 (85%) | 26 (96%) | **17 (85%)** |
| | In how many locations is there referral information re non- Māori non-Pakeha on public display? (up to 17) | | | |
| | 0-6 | 6 (22%) | 4 (16%) | **4 (20%)** |
| | 7-17 | 21 (78%) | 23 (84%) | **16 (80%)** |

| | "YES" responses | 84 mo FU Hospitals (%) | 96 mo FU Hospitals (%) | 108 mo FU DHBs (%) |
|---|---|---|---|---|
| 2.3 | Does the hospital provide temporary (<24 hours) safe shelter for victims of partner abuse who cannot go home or cannot be placed in a community-based shelter? If yes: | 20 (74%) | 24 (89%) | **20 (100%)** |
| | a) Does the design and use of the safe shelter support Māori cultural beliefs and practices? | 18 (67%) | **22 (82%)** | **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 | 26 (96%) | **27 (100%)** | **20 (100%)** |
| | b) medical staff | 19 (70%) | **24 (89%)** | **16 (80%)** |
| | c) administration | 19 (70%) | **20 (74%)** | **16 (80%)** |
| | d) other staff/employees | 25 (93%) | **27 (100%)** | **18 (90%)** |
| | If yes, did the assessment address staff knowledge and attitude about Māori and partner abuse? | 17 (63%) | **25 (93%)** | **16 (80%)** |
| 3.2 | How long has the hospital's partner abuse programme been in existence? | | | |
| | 1-24 months | 3 (11%) | **0 (0%)** | **0 (0%)** |
| | 24-48 months | 5 (19%) | **5 (19%)** | **0 (0%)** |
| | >48 months | 19 (70%) | **22 (81 %)** | **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? | 25 (93%) | **24 (89%)** | **17 (85%)** |
| | b) Does the Employee Assistance programme (or equivalent) maintain specific policies and procedures for dealing with employees experiencing partner abuse? | 12 (44%) | **12 (44%)** | **15 (75%)** |
| | c) Is the topic of partner abuse among employees covered in the hospital training sessions and/or orientation? | 25 (93%) | **27 (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? | 26 (96%) | **27 (100%)** | **20 (100%)** |
| | b) Are cultural issues discussed in the hospital's partner abuse training programme? | 25 (93%) | **27 (100%)** | **19 (95%)** |
| | c) Are translators/interpreters available for working with victims if English is not the victim's first language? | 27 (100%) | **27 (100%)** | **19 (95%)** |
| | d) Are referral information and brochures related to partner abuse available in languages other than English? | 27 (100%) | **27 (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*) | 27 (100%) | **25 (93%)** | **19 (95%)** |
| | a) 1 programme in the last 12 months? | 0 (0%) | **1 (4%)** | **2 (10%)** |
| | b) >1 programme in the last 12 months? | 27 (100%) | **24 (89%)** | **17 (85%)** |
| | c) Does the hospital collaborate with Māori community organizations and providers to deliver preventive outreach and public education activities? | 24 (89%) | **24 (89%)** | **18 (90%)** |

| | "YES" responses | 84 mo FU Hospitals (%) | 96 mo FU Hospitals (%) | 108 mo FU DHBs (%) |
|---|---|---|---|---|
| **CATEGORY 4. TRAINING OF PROVIDERS** | | | | |
| 4.1 | Has a formal training plan been developed for the institution? If yes: | 25 (93%) | **27 (100%)** | **19 (95%)** |
| | a) Does the plan include the provision of regular, ongoing education for clinical staff? | 26 (96%) | **27 (100%)** | **19 (95%)** |
| | b) Does the plan include the provision of regular, ongoing education for non-clinical staff? | 21 (78%) | **25 (93%)** | **18 (90%)** |
| 4.2 | During the past 12 months, has the hospital provided training on partner abuse: | | | |
| | a) as part of the mandatory orientation for new staff? | 26 (96%) | **27 (100%)** | **20 (100%)** |
| | b) to members of the clinical staff via colloquia or other sessions? | 27 (100%) | **27 (100%)** | **20 (100%)** |
| 4.3 | Does the hospital's training/education on partner abuse include information about: | | | |
| | a) definitions of partner abuse? | 25 (93%) | **27 (100%)** | **19 (95%)** |
| | b) dynamics of partner abuse? | 27 (100%) | **27 (100%)** | **19 (95%)** |
| | c) epidemiology? | 27 (100%) | **27 (100%)** | **19 (95%)** |
| | d) health consequences? | 27 (100%) | **27 (100%)** | **20 (100%)** |
| | e) strategies for screening? | 24 (89%) | **27 (100%)** | **20 (100%)** |
| | f) risk assessment? | 27 (100%) | **27 (100%)** | **20 (100%)** |
| | g) documentation? | 23 (85%) | **27 (100%)** | **19 (95%)** |
| | h) intervention? | 25 (93%) | **27 (100%)** | **20 (100%)** |
| | i) safety planning? | 24 (89%) | **27 (100%)** | **20 (100%)** |
| | j) community resources? | 25 (93%) | **27 (100%)** | **20 (100%)** |
| | k) reporting requirements? | 27 (100%) | **27 (100%)** | **19 (95%)** |
| | l) legal issues? | 27 (100%) | **27 (100%)** | **20 (100%)** |
| | m) confidentiality? | 27 (100%) | **27 (100%)** | **19 (95%)** |
| | n) cultural competency? | 26 (96%) | **27 (100%)** | **19 (95%)** |
| | o) clinical signs/symptoms? | 24 (89%) | **27 (100%)** | **19 (95%)** |
| | p) Māori models of health? | 23 (85%) | **27 (100%)** | **19 (95%)** |
| | q) risk assessment for children of victims? | 27 (100%) | **27 (100%)** | **20 (100%)** |
| | r) social, cultural, historic, and economic context in which Māori family violence occurs? | 22 (82%) | **27 (100%)** | **19 (95%)** |
| | s) te Tiriti o Waitangi? | 23 (85%) | **27 (100%)** | **19 (95%)** |
| | t) Māori service providers and community resources? | 24 (89%) | **27 (100%)** | **19 (95%)** |
| | u) service providers and community resources for ethnic and cultural groups other than Pakeha and Māori? | 23 (85%) | **27 (100%)** | **19 (95%)** |
| | v) partner abuse in same-sex relationships? | 25 (93%) | **27 (100%)** | **18 (90%)** |
| | w) service providers and community resources for victims of partner abuse who are in same-sex relationships? | 19 (70%) | **26 (96%)** | **18 (90%)** |

| | "YES" responses | 84 mo FU Hospitals (%) | 96 mo FU Hospitals (%) | 108 mo 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%) | **1 (4%)** | **1 (5%)** |
| | b) a team of hospital employees only? | 1 (4%) | **0(0%)** | **0 (0%)** |
| | c) a team, including community expert(s)? | 26 (96%) | **26 (96%)** | **19 (95%)** |
| | If provided by a team, does it include: | | | |
| | d) a Māori representative? | 25 (93%) | **26 (96%)** | **19 (95%)** |
| | e) a representative(s) of other ethnic/cultural groups? | 13 (48%) | **23 (85%)** | **16 (80%)** |
| **CATEGORY 5. SCREENING AND SAFETY ASSESSMENT** | | | | |
| 5.1 | Does the hospital use a standardized instrument, with at least 3 questions, to screen patients for partner abuse? If | 27 (100%) | **27 (100%)** | **19 (95%)** |
| | a) included, as a separate form, in the clinical record? | 0 (0%) | **1 (4%)** | **0 (0%)** |
| | b) incorporated as questions in the clinical record for all charts in ED or other out-patient area? | 4 (15%) | **0 (0%)** | **0 (0%)** |
| | c) incorporated as questions in the clinical record for all charts in two or more out-patient areas? | 16 (59%) | **17 (63%)** | **7 (35%)** |
| | d) incorporated as questions in clinical record for all charts in out-patient and in-patient areas? | 7 (26%) | **9 (33%)** | **12 (60%)** |
| 5.2 | What percentage of eligible patients have documentation of partner abuse screening (based upon random sample of charts in any clinical area)? | | | |
| | Not done or not applicable | 5 (19%) | **0 (0%)** | **1 (5%)** |
| | 0% - 10% | 2 (8%) | **5 (18%)** | **4 (20%)** |
| | 11% - 25% | 5 (19%) | **2 (8%)** | **1 (5%)** |
| | 26% - 50% | 9 (33%) | **11 (41%)** | **5 (25%)** |
| | 51% - 75% | 6 (22%) | **6 (22%)** | **5 (25%)** |
| | 76% - 100% | 0 (%) | **3 (11%)** | **4 (20%)** |
| 5.3 | Is a standardized safety assessment performed and discussed with victims who screen positive for partner abuse? If yes, does this: | 26 (96%) | **27 (100%)** | **18 (90%)** |
| | a) also assess the safety of any children in the victim's care? | 26 (96%) | **27 (100%)** | **18 (90%)** |
| **CATEGORY 6. DOCUMENTATION** | | | | |
| 6.1 | Does the hospital use a standardized documentation instrument to record known or suspected cases of partner abuse? If yes, does the form include: | 27 (100%) | **26 (96%)** | **19 (95%)** |
| | a) information on the results of partner abuse screening? | 27 (100%) | **26 (96%)** | **19 (95%)** |
| | b) the victim's description of current and/or past abuse? | 19 (70%) | **24 (89%)** | **19 (95%)** |
| | c) the name of the alleged perpetrator and relationship to the victim? | 18 (67%) | **24 (89%)** | **19 (95%)** |
| | d) a body map to document injuries? | 21 (78%) | **23 (85%)** | **18 (90%)** |
| | e) information documenting the referrals provided to the victim? | 26 (96%) | **26 (96%)** | **19 (95%)** |
| | f) in the case of Māori, information documenting whether the individual was offered a Māori advocate? | 19 (70%) | **25 (93%)** | **19 (95%)** |

| | "YES" responses | 84 mo FU Hospitals (%) | 96 mo FU Hospitals (%) | 108 mo FU DHBs (%) |
|---|---|---|---|---|
| 6.2 | Is forensic photography incorporated in the documentation procedure? If yes: | | | |
| | a) Is a fully operational camera with adequate film available in the treatment area? | 25 (93%) | **25 (93%)** | **19 (90%)** |
| | b) Do hospital staff receive on-going training on the use of the camera? | 21 (78%) | **18 (67%)** | **13 (65%)** |
| | c) Do hospital staff routinely offer to photograph all abused patients with injuries? | 11 (41%) | **16 (59%)** | **13 (65%)** |
| | d) Is a specific, unique consent-to-photograph form obtained prior to photographing any injuries? | 22 (82%) | **21 (78%)** | **16 (80%)** |
| | e) Do medical or nursing staff (not social work or a partner abuse advocate) photograph all injuries for medical documentation purposes, even if police obtain their own photographs for evidence purposes? | 22 (82%) | **17 (63%)** | **16 (80%)** |
| **CATEGORY 7. INTERVENTION SERVICES** | | | | |
| 7.1 | Is there a standard intervention checklist for staff to use/refer to when victims are identified? | 26 (96%) | **27 (100%)** | **19 (100%)** |
| 7.2 | Are on-site victim advocacy services provided? If yes, *choose one a-b and answer c-d)*: | 26 (96%) | **27 (100%)** | **20 (100%** |
| | a) A trained victim advocate provides services during certain hours. | 7 (26%) | **4 (15%)** | **2 (10%)** |
| | b) A trained victim advocate provides service at all times. | 19 (70%) | **23 (85%)** | **18 (90%)** |
| | c) is a Māori advocate is available on-site for Māori victims? | 27 (100%) | **27 (100%)** | **20 (100%)** |
| | d) is an advocate(s) of ethnic and cultural background other than Pakeha and Māori available onsite? | 24 (89%) | **26 (96%)** | **19 (95%)** |
| 7.3 | Are mental health/psychological assessments performed within the context of the programme? If yes, are they: | 26 (96%) | **27 (100%)** | **20 (100%)** |
| | a) available, when indicated? | 0 (0%) | **4 (15%)** | **8 (40%)** |
| | b) performed routinely? | 26 (96%) | **23 (85%)** | **12 (60%)** |
| 7.4 | Is transportation provided for victims, if needed? | 18 (67%) | **24 (89%)** | **20 (100%)** |
| 7.5 | Does the hospital partner abuse programme include follow-up contact and counselling with victims after the initial assessment? | 19 (70%) | **26 (96%)** | **19 (95%)** |
| 7.6 | Does the hospital partner abuse programme offer and provide on-site legal options counselling for victims? | 23 (85%) | **27 (100%)** | **20 (100%)** |
| 7.7 | Does the hospital partner abuse programme offer and provide partner abuse services for the children of victims? | 26 (96%) | **27 (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? | 26 (96%) | **27 (100%)** | **20 (100%)** |
| **CATEGORY 8. EVALUATION ACTIVITIES** | | | | |
| 8.1 | Are any formal evaluation procedures in place to monitor the quality of the partner abuse programme? If yes: | 27 (100%) | **26 (96%)** | **19 (95%)** |
| | a) Do evaluation activities include periodic monitoring of charts to audit for partner abuse screening? | 22 (82%) | **27 (100%)** | **18 (90%)** |
| | b) Do evaluation activities include peer-to-peer case reviews around partner abuse? | 23 (85%) | **26 (96%)** | **18 (90%)** |
| 8.2 | Do health care providers receive standardized feedback on their performance and on patients? | 15 (56%) | **22 (82%)** | **15 (75%)** |
| 8.3 | Is there any measurement of client satisfaction and/or community satisfaction with the partner abuse programme? | 17 (63%) | **21 (78%)** | **16 (80%)** |
| 8.4 | Is a quality framework (such as Whanau Ora) used to evaluate whether services are effective for Māori? | 10 (37%) | **10 (37%)** | **9 (45%)** |

| | "YES" responses | 84 mo FU Hospitals (%) | 96 mo FU Hospitals (%) | 108 mo FU DHBs (%) |
|---|---|---|---|---|
| **CATEGORY 9. COLLABORATION** | | | | |
| 9.1 | Does the hospital collaborate with local partner abuse programmes? If yes, | 27 (100%) | **27 (100%)** | **20 (100%)** |
| | a i) collaboration with training? | 26 (96%) | **26 (96%)** | **19 (95%)** |
| | ii) collaboration on policy and procedure development? | 27 (100%) | **27 (100%)** | **20 (100%)** |
| | iii) collaboration on partner abuse working group? | 25 (93%) | **25 (93%)** | **19 (95%)** |
| | iv) collaboration on site service provision? | 26 (96%) | **27 (100%)** | **20 (100%)** |
| | b) is collaboration with | | | |
| | i) Māori provider(s) or representative(s)? | 27 (100%) | **27 (100%)** | **20 (100%)** |
| | ii) Provider(s) or representative(s) for ethnic or cultural groups other than Pakeha or Māori? | 24 (89%) | **25 (93%)** | **18 (90%)** |
| 9.2 | Does the hospital collaborate with local police and courts in conjunction with their partner abuse programme? If yes: | 27 (100%) | **27 (100%)** | **20 (100%)** |
| | a) collaboration with training? | 25 (93%) | **26 (96%)** | **19 (95%)** |
| | b) collaboration on policy and procedure development? | 27 (100%) | **27 (100%)** | **20 (100%)** |
| | c) collaboration on partner abuse working group? | 24 (89%) | **25 (93%)** | **19 (95%)** |
| 9.3 | Is there collaboration with the partner abuse programme of other health care facilities?<br>If yes, which types of collaboration apply: | 27 (100%) | **27 (100%)** | **20 (100%)** |
| | a) within the same health care system? | 27 (100%) | **27 (100%)** | **20 (100%)** |
| | If yes, with a Māori health unit? | 27 (100%) | **26 (96%)** | **20 (100%)** |
| | b) with other systems in the region? | 27 (100%) | **27 (100%)** | **20 (100%)** |
| | If yes, with a Māori health provider? | 26 (96%) | **26 (96%)** | **19 (95%)** |

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

| | Median | | | | | | | | *Achieving Target Score ≥70* | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | ***B*** | ***$F_{12}$*** | ***$F_{30}$*** | ***$F_{48}$***[a] | ***$F_{60}$*** | ***$F_{84}$*** | ***$F_{96}$***[c] | ***$F_{108}$***[d] | ***B*** | ***$F_{12}$*** | ***$F_{30}$***[b] | ***$F_{48}$***[a] | ***$F_{60}$*** | ***$F_{84}$*** | ***$F_{96}$***[c] | ***$F_{108}$***[d]***/20*** |
| **Overall Score** | 36.7 | 50.8 | 59.3 | 74.5 | 80.9 | 86.5 | 90.8 | **92.3** | 2 (8%) | 3 (12%) | 4 (15%) | 17 (65%) | 21 (78%) | 25 (93%) | 27 (100%) | **19 (95%)** |
| **Domain Scores** | | | | | | | | | | | | | | | | |
| Policies and Procedures | 42.5 | 50.0 | 59.7 | 81.0 | 84.0 | 92.0 | 95.0 | **95.0** | 3 (12%) | 5 (20%) | 8 (29%) | 23 (89%) | 19 (70%) | 26 (96%) | 27 (100%) | **20 (100%)** |
| Safety & Security | - | - | - | 77.0 | 72.0 | 82.0 | 90.0 | **92.0** | - | - | - | 17 (65%) | 17 (63%) | 23 (85%) | 27 (100%) | **19 (95%)** |
| Collaboration | 46.5 | 70.8 | 85.4 | 82.5 | 91.0 | 94.0 | 97.0 | **98.0** | 5 (20%) | 15 (60%) | 20 (74%) | 21 (81%) | 25 (93%) | 26 (96%) | 27 (100%) | **20 (100%)** |
| Institutional Culture | 41.5 | 43.4 | 56.6 | 80.0 | 82.0 | 86.0 | 90.0 | **94.0** | 3 (12%) | 5 (20%) | 6 (22%) | 18 (69%) | 20 (74%) | 25 (93%) | 27 (100%) | **20 (100%)** |
| Training of Providers | 39.7 | 49.4 | 66.7 | 92.5 | 96.0 | 98.0 | 100.0 | **100.0** | 2 (8%) | 9 (36%) | 14 (52%) | 19 (73%) | 22 (82%) | 26 (96%) | 27 (100%) | **20 (100%)** |
| Intervention Services | 65.4 | 70.4 | 72.8 | 82.0 | 84.0 | 89.0 | 92.0 | **89.0** | 12(48%) | 13 (52%) | 15 (56%) | 21 (81%) | 22 (82%) | 27 (100%) | 27 (100%) | **20 (100%)** |
| Documentation | 19.0 | 28.6 | 58.4 | 83.5 | 83.0 | 87.0 | 93.0 | **95.5** | 5 (20%) | 5 (20%) | 8 (29%) | 22 (85%) | 19 (70%) | 22 (82%) | 24 (89%) | **19 (95%)** |
| Evaluation Activities | 35.1 | 36.6 | 36.6 | 29.8 | 58.5 | 72.0 | 75.5 | **72.75** | 1 (4%) | 1 (4%) | 5 (19%) | 3 (12%) | 7 (26%) | 14 (52%) | 18 (67%) | **11 (55%)** |
| Physical Environment | 23.0 | 28.0 | 35.6 | 68.0 | 91.0 | 100.0 | 100.0 | **100.0** | 1 (4%) | 2 (5%) | 2 (7%) | 12 (46%) | 26 (96%) | 27 (100%) | 27 (100%) | **19 (95%)** |

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

## APPENDIX J. Revised Child Abuse and Neglect Delphi Tool Item Analysis

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

| | "YES" responses | 84 mo FU Hospitals (%) | 96 mo FU Hospitals (%) | 108 mo FU DHBs (%) |
|---|---|---|---|---|
| **CATEGORY 1. POLICIES AND PROCEDURES** | | | | |
| 1.1 | Are there official, written DHB policies regarding the clinical assessment, appropriate questioning, and treatment of suspected abused and neglected children? If so, do the policies: | 26 (96%) | 27 (100%) | 20 (100%) |
| | a) Define child abuse and neglect? | 27 (100%) | 27 (100%) | 20 (100%) |
| | b) Mandate training on child abuse and neglect for staff? | 26 (96%) | 25 (93%) | 20 (100%) |
| | c) Outline age-appropriate protocols for risk assessment? | 20 (74%) | 23 (85%) | 18 (90%) |
| | d) Define who is responsible for risk assessment? | 27 (100%) | 27 (100%) | 19 (95%) |
| | e) Address the issue of contamination during interviewing? | 24 (89%) | 24 (89%) | 19 (95%) |
| | f) Address documentation? | 27 (100%) | 27 (100%) | 19 (95%) |
| | g) Address referrals for children and their families? | 27 (100%) | 27 (100%) | 19 (95%) |
| | h) Address child protection reporting requirements? | 27 (100%) | 27 (100%) | 18 (90%) |
| | i) Address the responsibilities to, and needs of, Māori? | 27 (100%) | 27 (100%) | 20 (100%) |
| | j) Address other cultural and/or ethnic groups? | 27 (100%) | 26 (96%) | 20 (100%) |
| 1.2 | Who is consulted regarding child protection policies and procedures? | | | |
| | Maori and Pacific? | 26 (96%) | 27 (100%) | 20 (100%) |
| | CYF? | 27 (100%) | 27 (100%) | 19 (95%) |
| | Police? | 24 (89%) | 27 (100%) | 18 (90%) |
| | Child abuse and neglect programme and Violence Intervention Programme staff? | 27 (100%) | 27 (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) | 25 (93%) | 27 (100%) | 18 (90%) |
| 1.3 | Is there evidence of a DHB-based child abuse and neglect steering group? If yes, does the: | | | |
| | a) Steering group meet at least every three (3) months? | 25 (93%) | 26 (97%) | 19 (95%) |
| | b) Include representatives from more than two departments? | 26 (96%) | 27 (100%) | 19 (95%) |

| | "YES" responses | 84 mo FU Hospitals (%) | 96 mo FU Hospitals (%) | 108 mo FU DHBs (%) |
|---|---|---|---|---|
| 1.4 | Does the DHB provide direct financial support for the child abuse and neglect programme (beyond VIP funding)? | 25 (93%) | 24 (89%) | 20 (100%) |
| | a) Is funding set aside specifically for Māori programmes and initiatives? | 13 (48%) | 19 (70%) | 15 (75%) |
| 1.5 | Is there a policy for identifying signs and symptoms of child abuse and neglect and for identifying children at high risk? a) in both inpatient and outpatient areas? | 27 (100%) | 27 (100%) | 20 (100%) |
| 1.6 | Are there procedures for security measures to be taken when suspected cases of child abuse and neglect are identified and the child is perceived to be at immediate risk? If yes, are the procedures: | | | |
| | a) written? | 27 (100%) | 27 (100%) | 19 (95%) |
| | b) include name/phone block? | 17 (63%) | 21 (78%) | 16 (80%) |
| | c) provide for safe transportation? | 19 (70%) | 20 (74%) | 16 (80%) |
| | d) account for the needs of Māori? | 16 (59%) | 23 (85%) | 17 (85%) |
| 1.7 | Is there an identifiable child protection coordinator at the DHB? If yes, is the coordinator position (choose one): | 26 (96%) | 27 (100%) | 20 (100%) |
| | a) part-time <0.5 FTE | 1 (4%) | 1 (4%) | 2 (10%) |
| | b) part-time ≥0.5 FTE? | 13 (48%) | 8 (29%) | 4 (20%) |
| | c) full-time? | 12 (44%) | 18 (67%) | 14 (70%) |
| 1.8 | Are there policies that outline the minimum expectation for all staff: | | | |
| | a) to attend mandatory training? | 26 (96%) | 25 (93%) | 20 (100%) |
| | b) to identification and referral children at risk? | 27 (100%) | 27 (100%) | 20 (100%) |
| | c) to reporting child protection concerns? | 25 (93%) | 27 (100%) | 19 (95%) |
| 1.9 | Do the child abuse and neglect policies and procedures indicate collaboration with government agencies and other relevant groups, such as the Police, CYF, refuge, and NNSVS ('men's programme provider')? | | | |
| | a) government agencies? | 27 (100%) | 27 (100%) | 20 (100%) |
| | b) community groups? | 26 (96%) | 27 (100%) | 20 (100%) |
| 1.10 | Are the DHB policies and procedures easily accessible and user-friendly? If yes, are | 27 (100%) | 27 (100%) | 20 (100%) |
| | a) they available on the DHB intranet? | 27 (100%) | 27 (100%) | 20 (100%) |
| | b) there supporting and reference documents appended to the appropriate policies and procedures? | 27 (100%) | 27 (100%) | 20 (100%) |
| | c) there translation materials to facilitate the application of policy and procedures, such as flowcharts and algorithms? | 27 (100%) | 27 (100%) | 19 (95%) |
| 1.11 | Are the DHB policies and procedures cross-referenced to other forms of family violence, such as partner abuse and elder abuse? | 26 (96%) | 26 (96%) | 20 (100%) |

| | "YES" responses | 84 mo FU Hospitals (%) | 96 mo FU Hospitals (%) | 108 mo FU DHBs (%) |
|---|---|---|---|---|
| **CATEGORY 2. SAFETY & SECURITY** | | | | |
| 2.1 | Does the DHB have a policy in place that all children are assessed when signs and symptoms are suggestive of abuse and/or neglect? | 25 (93%) | 27 (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?<br>Which types of collaboration apply: | 26 (96%) | 27 (100%) | 19 (95%) |
| | b) within the DHB? | 27 (100%) | 27 (100%) | 20 (100%) |
| | c) with other groups and agencies in the region? | 26 (96%) | 27 (100%) | 19 (95%) |
| | d) with Māori and Pacific health providers? | 24 (89%) | 27 (100%) | 20 (100%) |
| | e) with other relevant ethnic/cultural groups? | 22 (82%) | 24 (89%) | 17 (85%) |
| | f) with the primary health sector? | 11 (41%) | 21 (78%) | 19 (95%) |
| 2.3 | Does the DHB have a protocol to promote the safety of children identified at risk of abuse or neglect? | | | |
| | a) within the DHB? | 27 (100%) | 27 (100%) | 20 (100%) |
| | b) with relevant primary health care providers as part of discharge planning? | 12 (44%) | 19 (70%) | 19 (95%) |
| | c) by accessing necessary support services for the child and family to promote ongoing safety of the child? | 22 (82%) | 27 (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? | 25 (93%) | 27 (100%) | 19 (95%) |
| 2.5 | Do the DHB services have an alert system or a central database recording any concerns about children at risk of abuse and neglect in place? | | | |
| | b) a local alert system in acute care setting | 25 (93%) | 24 (89%) | 19 (95%) |
| | c) a local alert system in community setting, including PHO | 8 (30%) | 6 (22%) | 9 (45%) |
| | d) a process for notification of alert placements to relevant providers | 18 (67%) | 15 (56%) | 14 (70%) |
| | e) participation in a national alert system (108 Mo. note 8 NCPAS approved + 3 self-reporting that in process) | 8 (30%) | 13 (48%) | 11 (55%) |
| | f) clear criteria for identifying levels of risk, and process that guides the use of the alert system | 18 (67%) | 18 (67%) | 13 (65%) |
| 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? | 27 (100%) | 26 (96%) | 19 (95%) |

| | "YES" responses | 84 mo FU Hospitals (%) | 96 mo FU Hospitals (%) | 108 mo FU DHBs (%) |
|---|---|---|---|---|
| | b) process for notifying CYF and/or other agencies? | 26 (96%) | 26 (96%) | 19 (95%) |
| | c) referral form that requires the documentation of the risk assessed for these children? | 13 (48%) | 19 (70.4%) | 18 (90%) |
| | **CATEGORY 3. COLLABORATION** | | | |
| 3.1 | Does the DHB collaborate with CYF and NGO child advocacy and protection? | 27 (100%) | 27 (100%) | 20 (100%) |
| | a) which types of collaboration apply: | | | |
| | i) collaboration with training? | 27 (100%) | 27 (100%) | 20 (100%) |
| | ii) collaboration on policy and procedure development? | 27 (100%) | 27 (100%) | 20 (100%) |
| | iii) collaboration on child abuse and neglect task force? | 27 (100%) | 27 (100%) | 19 (95%) |
| | iv) collaboration on site service provision? | 27 (100%) | 27 (100%) | 19 (95%) |
| | v) collaboration is two-way? | 27 (100%) | 27 (100%) | 20 (100%) |
| | b) is collaboration with: | | | |
| | i) CYF? | 27 (100%) | 27 (100%) | 20 (100%) |
| | ii) NGOs and other agencies such as Women's Refuge? | 27 (100%) | 27 (100%) | 20 (100%) |
| | iii) Māori provider(s) or representative(s)? | 27 (100%) | 27 (100%) | 20 (100%) |
| | iv) Provider(s) or representative(s) for ethnic or cultural groups other than Pakeha or Māori? | 25 (93%) | 27 (100%) | 18 (90%) |
| | c) services, departments and between relevant staff within the DHB evident? | 27 (100%) | 27 (100%) | 20 (100%) |
| 3.2 | Does the DHB collaborate with police and prosecution agencies in conjunction with their child abuse and neglect programme? If yes, which types of collaboration apply: | 27 (100%) | 27 (100%) | 20 (100%) |
| | a) collaboration with training? | 27 (100%) | 27 (100%) | 20 (100%) |
| | b) collaboration on policy and procedure development? | 26 (96%) | 27 (100%) | 20 (100%) |
| | c) collaboration on child abuse and neglect task force? | 26 (96%) | 27 (100%) | 19 (95%) |
| 3.3 | Is there collaboration of the child abuse and neglect programme with other health care facilities? If yes, which types of collaboration apply: | 27 (100%) | 27 (100%) | 20 (100%) |
| | a) within the DHB? | 27 (100%) | 27 (100%) | 20 (100%) |
| | b) with a Māori unit? | 27 (100%) | 27 (100%) | 20 (100%) |
| | c) with other groups and agencies in the region? | 27 (100%) | 27 (100%) | 20 (100%) |
| | d) with a Māori health provider? | 24 (89%) | 25 (93%) | 19 (95%) |
| | e) with the primary health care sector? | 25 (93%) | 27 (100%) | 20 (100%) |
| | f) with national network of child protection and family violence coordinators? | 27 (100%) | 27 (100%) | 20 (100%) |

| | "YES" responses | 84 mo FU Hospitals (%) | 96 mo FU Hospitals (%) | 108 mo FU DHBs (%) |
|---|---|---|---|---|
| 3.4 | Do relevant staff have membership on, or attend: | | | |
| | a) the interdisciplinary child protection team? | 27 (100%) | 27 (100%) | 20 (100%) |
| | b) Child abuse team meetings? | 27 (100%) | 27 (100%) | 20 (100%) |
| | c) Sexual abuse team meetings? | 25 (93%) | 26 (96%) | 18 (90%) |
| | d) CYF Care and Protection Resource Panel? | 24 (89%) | 25 (93%) | 17 (85%) |
| | e) National Network of Family Violence Intervention Coordinators? | 27 (100%) | 27 (100%) | 20 (100%) |
| 3.5 | Does the DHB have a Memorandum of Understanding that enables the sharing of details of children at risk for entry on their database with the Police and/or CYF? | | | |
| | a) CYF? | 22 (82%) | 25 (93%) | 20 (100%) |
| | b) the Police? | 20 (74%) | 25 (93%) | 20 (100%) |
| 3.6 | Does the DHB have a Memorandum of Understanding or service agreement that enables timely medical examinations to support: | | | |
| | a) CYF? | 15 (56%) | 23 (85%) | 18 (90%) |
| | b) Police? | 16 (59%) | 23 (85%) | 18 (90%) |
| | c) DSAC? | 14 (52%) | 18 (67%) | 17 (85%) |
| **CATEGORY 4. INSTITUTIONAL CULTURE** | | | | |
| 4.1 | Does the DHB senior management support and promote the child abuse and neglect programme? | | | |
| | a) child protection is in the DHB Strategic Plan? | 20 (74%) | 21 (78%) | 15 (75%) |
| | b) child protection is in the DHB Annual Plan? | 23 (85%) | 26 (96%) | 16 (80%) |
| | c) the child protection programme is adequately resourced, including dedicated programme staff? | 12 (44%) | 19 (70%) | 16 (80%) |
| | d) a working group of skilled and trained people who operationalises policies and procedures, in addition to the child protection coordinator? | 27 (100%) | 27 (100%) | 20 (100%) |
| | e) attendance at training as a key performance indicator (KPI) for staff? | 13 (48%) | 16 (59%) | 13 (65%) |
| | f) roles of those in the child abuse and neglect working team are included in position descriptions? | 19 (70%) | 14 (52%) | 15 (75%) |
| | g) DHB representation on the CYF Care and Protection Resource Panel? | 25 (93%) | 25 (93%) | 17 (85%) |
| | h) the Child Protection Coordinator is supported to attend the VIP Coordinator Meetings? | 27 (100%) | 27 (100%) | 20 (100%) |

| | "YES" responses | 84 mo FU Hospitals (%) | 96 mo FU Hospitals (%) | 108 mo FU DHBs (%) |
|---|---|---|---|---|
| 4.2 | In the last 3 years, has there been a formal (written) assessment of the DHB staff's knowledge and attitude about child abuse and neglect? | 26 (96%) | 27 (100%) | 20 (100% |
| | a) nursing staff | 26 (96%) | 27 (100%) | 20 (100%) |
| | b) medical staff | 20 (74%) | 24 (89%) | 18 (90%) |
| | c) administration | 17 (63%) | 18 (67%) | 15 (75%) |
| | d) other staff/employees | 24 (84%) | 25 (93%) | 18 (90%) |
| | If yes, did the assessment address staff knowledge and attitude about Māori and child abuse and neglect? | 15 (56%) | 23 (85%) | 17 (85%) |
| 4.3 | How long has the hospital's child abuse and neglect programme been in existence? | | | |
| | a) 24-48 months | 2 (7%) | 1 (4%) | |
| | b) >48 months | 25 (93%) | 26 (96%) | 20 (100%) |
| 4.4 | Does the DHB's child abuse and neglect programme address cultural issues? | | | |
| | a) does the DHBs policies specifically require implementation of the child abuse and neglect clinical assessment policy regardless of the child's cultural background? | 27 (100%) | 27 (100%) | 20 (100%) |
| | b) does the child protection coordinator and the steering group work with the Māori health unit and other cultural/ethnic groups relevant to the DHBs demographics? | 27 (100%) | 27 (100%) | 20 (100%) |
| | c) Are cultural issues discussed in the hospital's child abuse and neglect training programme? | 27 (100%) | 25 (93%) | 20 (100%) |
| | d) are translators/interpreters available for working with victims if English is not the victim's first language? | 27 (100%) | 27 (100%) | 20 (100%) |
| | e) Are referral information and brochures related to child abuse and neglect available in languages other than English? | 26 (96%) | 23 (85%) | 16 (80%) |
| 4.5 | Does the DHB participate in prevention outreach/public education activities on the topic of child abuse and neglect? | 27 (100%) | 27 (100%) | 20 (100%) |
| | a) 1 programme in the last 12 months? | 3 (11%) | 1 (4%) | 2 (10%) |
| | b) >1 programme in the last 12 months? | 24 (89%) | 26 (96%) | 18 (90%) |
| | c) Does the DHB collaborate with Māori community organisations and providers to deliver preventive outreach and public education activities? | 25 (93%) | 19 (70%) | 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? | 23 (85%) | 25 (93%) | 20 (100%) |
| | a) is a list of supportive interventions available? | 20 (74%) | 27 (100%) | 20 (100%) |
| | b) are staff aware of how to access support and interventions available? | 23 (85%) | 27 (100%) | 20 (100%) |
| 4.7 | Is there evidence of coordination between the DHB child abuse and neglect programme in collaboration with other violence intervention programmes? | 27 (100%) | 27 (100%) | 19 (95%) |
| | a) is there is a referral mechanism? | 26 (96%) | 27 (100%) | 20 (100%) |

| | "YES" responses | 84 mo FU Hospitals (%) | 96 mo FU Hospitals (%) | 108 mo FU DHBs (%) |
|---|---|---|---|---|
| 4.8 | Does the child protection policy require mandatory use of DHB approved translators when English is not the victim's or caregiver's first language? | | | |
| | a) DHB approved translators being used? | 21 (78%) | 25 (93%) | 20 (100%) |
| | b) a list of translators is accessible? | 26 (96%) | 26 (96%) | 20 (100%) |
| | c) translators used that are gender and age appropriate? | 16 (59%) | 18 (67%) | 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 (70%) | 26 (96%) | 20 (100%) |
| | b) access to child abuse and neglect training? | 22 (82%) | 26 (96%) | 19 (95%) |
| | c) coordination of referral processes between the DHB and primary health care sectors? | 13 (48%) | 20 (74%) | 17 (85%) |
| | d) ongoing relationships and activities that focus on prevention and promoting child protection? | 23 (85%) | 25 (93%) | 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? | 25 (93%) | 26 (96%) | 19 (95%) |
| | b) an operational plan that outlines the specifics of the programme of training? | 25 (93%) | 27 (100%) | 19 (95%) |
| | c) Does the plan include the provision of regular, ongoing education for clinical staff? | 25 (93%) | 27 (100%) | 19 (95%) |
| | d) Does the plan include the provision of regular, ongoing education for non-clinical staff? | 22 (82%) | 25 (93%) | 19 (95%) |
| 5.2 | During the past 12 months, has the DHB provided training on child abuse and neglect? | | | |
| | a) as part of the mandatory orientation for new staff? | 27 (100%) | 27 (100%) | 19 (95%) |
| | b) to members of the clinical staff via colloquia or other sessions? | 27 (100%) | 27 (100%) | 20 (100%) |
| 5.3 | Does the training/education on child abuse and neglect include information about: | | | |
| | a) definitions of child abuse and neglect? | 27 (100%) | 27 (100%) | 20 (100%) |
| | b) dynamics of child abuse and neglect? | 27 (100%) | 27 (100%) | 20 (100%) |
| | c) child advocacy? | 25 (93%) | 27 (100%) | 20 (100%) |
| | d) appropriate child-centred interviewing? | 26 (96%) | 26 (96%) | 20 (100%) |
| | e) issues of contamination? | 27 (100%) | 27 (100%) | 20 (100%) |
| | f) ethical dilemmas? | 26 (96%) | 27 (100%) | 20 (100%) |
| | g) conflict of interest? | 25 (93%) | 27 (100%) | 20 (100%) |
| | h) epidemiology? | 27 (100%) | 27 (100%) | 20 (100%) |
| | i) health consequences? | 26 (96%) | 25 (93%) | 20 (100%) |

| | "YES" responses | 84 mo FU Hospitals (%) | 96 mo FU Hospitals (%) | 108 mo FU DHBs (%) |
|---|---|---|---|---|
| | j) identifying high risk indicators? | 27 (100%) | 27 (100%) | 20 (100%) |
| | k) physical signs and symptoms? | 27 (100%) | 27 (100%) | 20 (100%) |
| | l) dual assessment with partner violence? | 26 (96%) | 27 (100%) | 19 (100%) |
| | m) documentation? | 27 (100%) | 27 (100%) | 20 (100%) |
| | n) intervention? | 27 (100%) | 27 (100%) | 20 (100%) |
| | o) safety planning? | 26 (96%) | 27 (100%) | 20 (100%) |
| | p) community resources? | 26 (96%) | 27 (100%) | 20 (100%) |
| | q) child protection reporting requirements? | 27 (100%) | 27 (100%) | 20 (100%) |
| | r) linking with the police and child youth and family? | 27 (100%) | 27 (100%) | 20 (100%) |
| | s) limits of confidentiality? | 27 (100%) | 27 (100%) | 20 (100%) |
| | t) age appropriate assessment and intervention? | 25 (93%) | 27 (100%) | 19 (95%) |
| | u) cultural issues? | 26 (96%) | 27 (100%) | 20 (100%) |
| | v) link between partner violence and child abuse and neglect? | 27 (100%) | 27 (100%) | 20 (100%) |
| | w) Māori models of health? | 21 (78%) | 24 (89%) | 19 (95%)) |
| | x) the social, cultural, historic, and economic context in which Māori family violence occurs? | 22 (82%) | 23 (85%) | 18 (90%) |
| | y) Te Tiriti o Waitangi? | 23 (85%) | 26 (96%) | 20 (100%) |
| | z) Māori service providers and community resources? | 25 (93%) | 27 (100%) | 20 (100%) |
| | aa) service providers and community resources for ethic and cultural groups other than Pakeha and Māori? | 23 (85%) | 27 (100%) | 19 (100%) |
| | ab) If all sub-items are evident, bonus 1.5 | 18 (67%) | 20 (74%) | 16 (80%) |
| 5.4 | Is the child abuse and neglect training provided by: (*choose one of a-d and answer e-f)* | | | |
| | c) a team of DHB employees only? | 1 (4%) | 0 (0%) | 1 (5%) |
| | d) a team, including community expert(s)? | 26 (96%) | 27 (100%) | 19 (95%) |
| | e) a Child Youth and Family statutory social worker? | 26 (96%) | 27 (100%) | 19 (95%) |
| | f) a Māori representative? | 26 (96%) | 26 (96%) | 19 (95%) |
| | g) a representative(s) of other ethnic/cultural groups? | 16 (59%) | 22 (82%) | 13 (65%) |
| 5.5 | Is the training delivered in collaboration with various disciplines, and providers of child protection services, such as CYF, Police and community agencies? | 26 (96%) | 27 (100%) | 20 (100%) |

| | "YES" responses | 84 mo FU Hospitals (%) | 96 mo FU Hospitals (%) | 108 mo FU DHBs (%) |
|---|---|---|---|---|
| 5.6 | Does the plan include a range of teaching and learning approaches used to deliver training on child abuse and neglect? | 26 (96%) | 27 (100%) | 20 (100%) |
| **CATEGORY 6. INTERVENTION SERVICES** | | | | |
| 6.1 | Is there a standard intervention checklist for staff to use/refer to when suspected cases of child abuse and neglect are identified? | 27 (100%) | 27 (100%) | 20 (100%) |
| 6.2 | Are child protection services available "on-site"? If yes, *choose one of a-b and answer c-d*: | 27 (100%) | 27 (100%) | 20 (100%) |
| | a) A member of the child protection team or social worker provides services during certain hours. | 5 (19%) | 3 (11%) | 5 (25%) |
| | b) A member of the child protection team or social worker provides service at all times. | 22 (82%) | 24 (89%) | 15 (75%) |
| | c) A Māori advocate or social worker is available "on-site" for Māori victims. | 27 (100%) | 26 (96%) | 19 (95%) |
| | d) An advocate of ethnic and cultural background other Pakeha and Māori is available onsite. | 17 (63%) | 23 (85%) | 16 (80%) |
| 6.3 | Are mental health/psychological assessments performed within the context of the programme? If yes, are they: (*choose a or b and answer c*) | 27 (100%) | 27 (100%) | 20 (100%) |
| | a) available, when indicated? | 18 (67%) | 11 (41%) | 12 (60%) |
| | b) performed routinely? | 9 (33%) | 16 (59%) | 8 (40%) |
| | c) age-appropriate? | 26 (96%) | 27 (100%) | 20 (100%) |
| 6.4 | Do the intervention services include: | | | |
| | a) access to physical and sexual examination? | 27 (100%) | 27 (100%) | 20 (100%) |
| | b) access to specialised sexual abuse services? | 27 (100%) | 27 (100%) | 20 (100%) |
| | c) family focused interventions? | 24 (89%) | 27 (100%) | 19 (100%) |
| | d) support services that include relevant NGOs, or acute crisis counsellors/support? | 27 (100%) | 27 (100%) | 19 (95%) |
| | e) culturally appropriate advocacy and support? | 27 (100%) | 27 (100%) | 19 (95%) |
| 6.5 | Are Social Workers available? | | | |
| | a) Monday to Friday 8 am to 4 pm service, with referrals outside of these hours? | 15 (56%) | 16 (59%) | 12 (60%) |
| | b) 0n-call after 4 pm and at weekends? | 3 (11%) | 3 (11%) | 3 (15%) |
| | c) as a 24 hour service? | 9 (33%) | 8 (30%) | 5 (25%) |
| 6.6 | Is there a current list of relevant services available to support child and family safety? | 25 (93%) | 27 (100%) | 20 (100%) |
| 6.7 | Is provision made for transport for victims and their families, if needed? | 23 (85%) | 24 (89%) | 20 (100%) |
| 6.8 | Does the DHB child abuse and neglect programme include follow-up contact and counselling with victims after the initial assessment? | 22 (82%) | 27 (100%) | 20 (100%) |

| | "YES" responses | 84 mo FU Hospitals (%) | 96 mo FU Hospitals (%) | 108 mo FU DHBs (%) |
|---|---|---|---|---|
| 6.9 | Does the child abuse and neglect programme assess and provide family violence intervention services and appropriate referral for: | | | |
| | a) the mother | 26 (96%) | 26 (96%) | 20 (100%) |
| | b) siblings | 27 (100%) | 26 (96%) | 19 (95%) |
| 6.10 | Is there evidence of coordination with CYF and the Police for children identified at risk of child abuse and neglect? | 27 (100%) | 27 (100%) | 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: | 27 (100%) | 26 (96%) | |
| | a) Reason for presentation? | 27 (100%) | 26 (96%) | 19 (95%) |
| | b) information generated by risk assessment? | 21 (78%) | 25 (93%) | 18 (90%) |
| | c) the victim or caregiver's description of current and/or past abuse? | 22 (82%) | 26 (96%) | 19 (95%) |
| | d) the name of the alleged perpetrator and relationship to the victim? | 13 (48%) | 21 (78%) | 16 (80%) |
| | e) a body map to document injuries? | 19 (70%) | 25 (93%) | 19 (95%) |
| | f) Past medical history? | 19 (70%) | 22 (82%) | 18 (90%) |
| | g) A social history, including living circumstances? | 13 (48%) | 24 (89%) | 18 (90%) |
| | h) An injury assessment, including photographic evidence (if appropriate)? | 19 (70%) | 23 (85%) | 17 (85%) |
| | i) The interventions undertaken? | 19 (70%) | 23 (85%) | 18 (90%) |
| | j) information documenting the referrals provided to the victim and their family? | 19 (70%) | 21 (78%) | 19 (95%) |
| | k) in the case of Māori, information documenting whether the victim and their family were offered a Māori advocate? | 12 (44%) | 19 (70%) | 14 (70%) |
| 7.2 | Does the DHB have sexual abuse specific forms that include: | | | |
| | a) a genital diagram? | 24 (89%) | 24 (89%) | 19 (95%) |
| | b) a consent form? | 23 (85%) | 23 (85%) | 17 (85%) |
| 7.3 | Is there evidence of use of a standardised referral form and process for CYF and/or Police notification? If yes, is a referral form and process available for: | 27 (100%) | 27 (100%) | 20 (100%) |
| | a) CYF notification? | 27 (100%) | 27 (100%) | 20 (100%) |
| | b) Police notification? | 17 (63%) | 19 (70%) | 15 (75%) |
| 7.4 | Are staff provided training on documentation for children regarding abuse and neglect? | 27 (100%) | 27 (100%) | 20 (100%) |

| | "YES" responses | 84 mo FU Hospitals (%) | 96 mo FU Hospitals (%) | 108 mo FU DHBs (%) |
|---|---|---|---|---|
| **CATEGORY 8. EVALUATION ACTIVITIES** | | | | |
| 8.1 | Are any formal evaluation procedures in place to monitor the quality of the child abuse and neglect programme? If yes: | | | |
| | a) Do evaluation activities include periodic monitoring of implementation of child abuse and neglect clinical assessment policy? | 26 (96%) | 26 (96%) | 20 (100%) |
| | b) Is the evaluation process standardised? | 22 (82%) | 25 (93%) | 17 (85%) |
| | c) Do evaluation activities measure outcomes, either for entire programme or components thereof? | 26 (96%) | 26 (96%) | 18 (90%) |
| | d) Does the evaluation of the programme include relevant review/audit of the following activities: | | | |
| | Identification, risk assessment, admissions and referral activities? | 18 (67%) | 24 (89%) | 18 (90%) |
| | Monitoring trends re demographics, risk factors, and types of abuse? | 14 (52%) | 16 (59%) | 15 (75%) |
| | Documentation? | 20 (74%) | 22 (82%) | 17 (85%) |
| | Referrals to CYF and the Police? | 21 (78%) | 23 (85%) | 18 (90%) |
| | Case reviews? | 23 (85%) | 24 (89%) | 17 (85%) |
| | Critical incidents? | 20 (74%) | 21 (78%) | 19 (95%) |
| | Mortality morbidity review? | 20 (74%) | 24 (89%) | 19 (95%) |
| | Policy and procedure reviews? | 26 (96%) | 27 (100%) | 20 (100%) |
| | e) Do the evaluation activities include: | | | |
| | Multidisciplinary team members? | 26 (96%) | 27 (100%) | 20 (100%) |
| | Police? | 22 (82%) | 27 (100%) | 19 (95%) |
| | CYF? | 26 (96%) | 27 (100%) | 19 (95%) |
| | Community agencies? | 20 (74%) | 26 (96%) | 19 (95%) |
| 8.2 | Is there evidence of feedback on the child abuse and neglect programme from community agencies and government services providers, such as CYF, the Police, refuge, and well child providers? | 24 (89%) | 24 (89%) | 16 (80%) |
| 8.3 | Do health care providers receive standardized feedback on their performance and on patients from CYF? | 18 (67%) | 23 (85%) | 14 (70%) |
| 8.4 | Is there any measurement of client satisfaction and community satisfaction with the child abuse and neglect programme? | | | |
| | a) client satisfaction? | 7 (26%) | 11 (41%) | 10 (50%) |
| | b) community satisfaction? | 17 (63%) | 23 (85%) | 14 (70%) |

| | "YES" responses | 84 mo FU Hospitals (%) | 96 mo FU Hospitals (%) | 108 mo FU DHBs (%) |
|---|---|---|---|---|
| 8.5 | Is a quality framework used to evaluate whether services are effective for Māori? | 8 (30%) | 14 (52%) | 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? | 20 (74%) | 19 (70%) | 14 (70%) |
| 8.7 | Is the child abuse and neglect programme evident in the DHB quality and risk programme? | 16 (59%) | 27 (100%) | 19 (95%) |
| 8.8 | Is the responsibility for acting on evaluation recommendations specified in the policies and procedures? | 17 (63%) | 11 (41%) | 11 (55%) |
| **CATEGORY 9. PHYSICAL ENVIRONMENT** | | | | |
| 9.1 | How many locations with posters/images relevant to children and young people which are they child-friendly, contain messages about child rights and safety, and contain Māori and other relevant cultural or ethnic images? | | | |
| | a) <10 posters or images | 0 (0%) | 0 (0%) | 1 (5%) |
| | b) 10-20 posters or images | 2 (7%) | 1 (4%) | 3 (15%) |
| | c) >20 posters or images | 25 (93%) | 26 (96%) | 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 | 2 (7%) | 0 (0%) | 1 (5%) |
| | b) 10-20 locations | 2 (7%) | 1 (4%) | 4 (20%) |
| | c) >20 locations | 23 (85%) | 26 (96%) | 15 (75%) |
| 9.3 | Are there designated private spaces available for interviewing? | | | |
| | a) > 4 locations? | 27 (100%) | 27 (100%) | 20 (100%) |
| 9.4 | Does the DHB provide temporary (<24 hours) safe shelter for victims of child abuse and neglect and their families who cannot go home or cannot be placed in a community-based shelter until CYF or a refuge intervene? | | | |
| | a) 'Social admissions" mentioned in child abuse and neglect policies? | 23 (85%) | 24 (89%) | 17 (85%) |
| | b) Temporary safe shelter is available? | 25 (93%) | 27 (100%) | 18 (90%) |