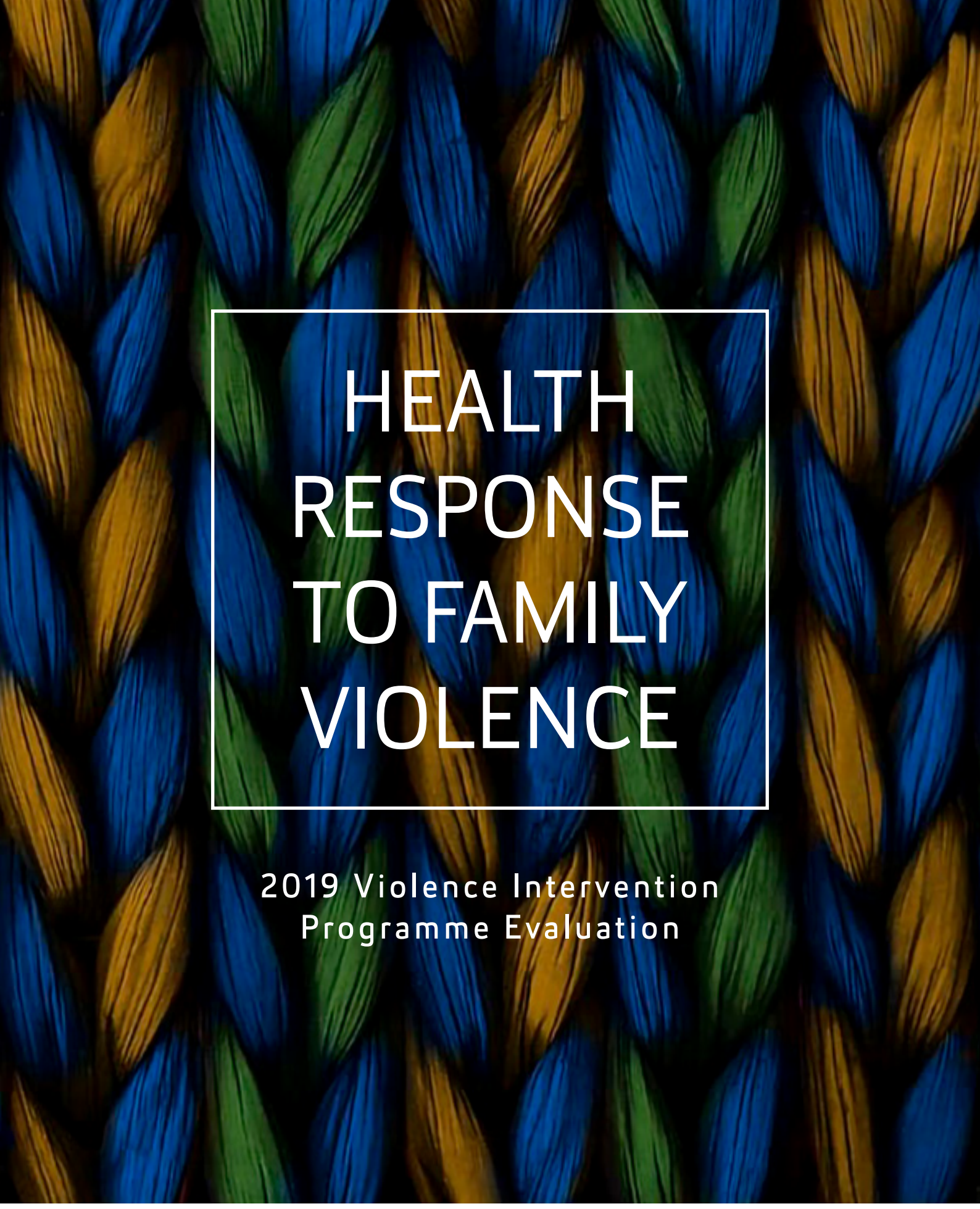

HEALTH RESPONSE TO FAMILY VIOLENCE

2019 Violence Intervention Programme Evaluation

CENTRE FOR INTERDISCIPLINARY TRAUMA RESEARCH
AUT UNIVERSITY

VIP violence intervention programme

MINISTRY OF HEALTH
MANATŪ HAUORA

AUT

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Disclaimer

The Ministry of Health commissioned this report. The views expressed in this report are those of the authors and do not necessarily represent the views of the Ministry of Health.

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HEALTH RESPONSE TO FAMILY VIOLENCE:
2019 VIOLENCE INTERVENTION PROGRAMME EVALUATION

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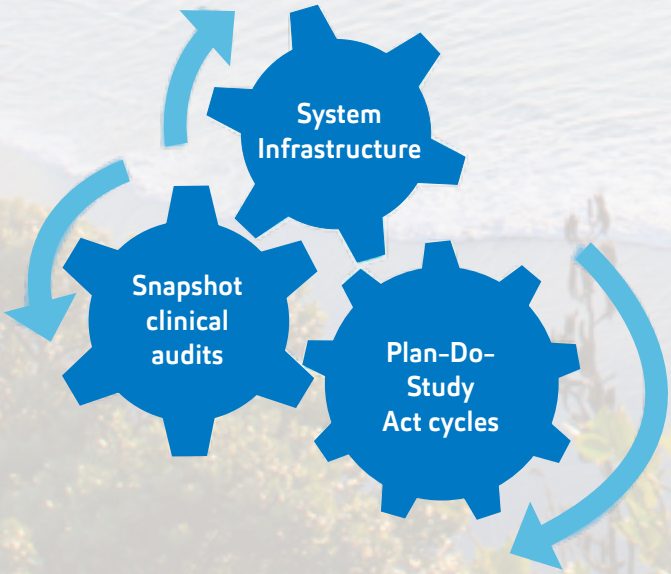
EXECUTIVE **SUMMARY**

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

This report documents three VIP evaluation work streams (1) DHB programme inputs (system infrastructure indicators), (2) DHB outputs (snapshot clinical audits of service delivery) and (3) DHB improvements (based on model for improvement Plan-Do-Study-Act cycles).

In this report, we focus on DHB data for the period 1 July 2018 to 30 June 2019. This report provides the Ministry, DHBs and service users with information and accountability data regarding VIP implementation. VIP contributes to the whole of government Family Violence & Sexual Violence Work Programme.[3]



System Infrastructure

Scaling up a quality sustainable health response to family violence is reliant on quality systems.[4-10] DHBs provide self audit data on 58 system indicators for IPV and CAN present for the period 1 July 2018 to 30 June 2019. The indicators are categorised across nine standardised domains. Overall and domain scores can range between 0 and 100, with higher scores indicating greater levels of programme development.

New Zealand Violence Intervention Programmes have worked hard to have systems in place to support a health response to intimate partner violence and child abuse and neglect. Nationally, the typical infrastructure score was 80; with 50% of DHBs scoring 80 or above.

DHBs continue to score consistently high in *Policies and Procedures* and *Documentation* infrastructure domains. Compared to 2018, six infrastructure domain scores increased in 2019. The largest improvement was in *Quality Improvement*, increasing by 20 points, yet the domain continues to be low performing with wide variation amongst DHBs. Small increases occurred in *Organisational Leadership, Resource Funding, Cultural Responsiveness and Collaboration*. The *VIP Practices* domain score remained unchanged and is the lowest performing domain.

MEDIAN VIP INFRASTRUCTURE SCORE

VIP INFRASTRUCTURE DOMAINS

HIGH PERFORMANCE (≥ 80)
Policies & Procedures
Collaboration
Documentation

MEDIUM PERFORMANCE (≥50 - <80)
Organisational Leadership
Training and Support
Resource Funding

LOW PERFORMANCE (<50)
Quality Improvement
VIP Practices

Snapshot Clinical Audits

VIP snapshot clinical audits use a nationally standardised reporting process to monitor service delivery and inform performance improvements. They signal a programme focus on accountability, measurement and performance improvements in the delivery of services for children and their whānau or families.[11] Snapshot audits allow pooling of DHB data to estimate (a) VIP output – women and children assessed for violence and abuse – as well as (b) VIP outcomes – women and children with a violence concern who received specialist assistance.

DHB snapshot audits involve annual retrospective reviews of a random selection of 25 clinical records from the three-month period 1 April to 30 June for each of the target services. Along with an estimated eligible population, we provide national estimates of the number of health clients seeking care within the services during the audit period who received VIP assessment within each service. Snapshot clinical audit targets for 2019 included: IPV and CAN assessment rates ≥ 80%; IPV disclosure 5–25%; and CAN concern rates ≥ 5%.

During the three month audit period (April – June) in 2019:

2019 VIP CHILD ABUSE & NEGLECT (CAN) SERVICE DELIVERY

Of children under two years of age who visited an emergency department

55% (n=9,308) were assessed for CAN.

Of those assessed, a child protection concern was noted for

5% (n=495).

Of those with a child protection concern,

90% received specialist consultation.

2019 VIP INTIMATE PARTNER VIOLENCE (IPV) SERVICE DELIVERY

The proportion of eligible women assessed for IPV ranged between

28% in the emergency department to

75% in sexual health services.

Of women assessed, the proportion who disclosed IPV ranged from

7% in the emergency department

to **29%** in community mental health services.

Of women who disclosed IPV, the proportion who received a specialist referral ranged from

63% in sexual health services to

90% in child health in-patient services.

Quality improvement initiatives: Model for Improvement Plan-Do-Study-Act (PDSA)

The Model for Improvement PDSA process[12] provides a mechanism to improve the consistency and quality of family violence service delivery. Of the 37 PDSA cycle plans submitted by 19 DHBs, 11 were completed within the following four months, documenting diverse system learning. Three PDSA plans did not generate the predicted change, but the system learning informed future actions. Below are examples of individual DHB learning from PDSA cycles.

EXAMPLES OF SYSTEM LEARNING INCLUDED:

- Identifying barriers to low IPV enquiry rates.
- Clarifying eligibility critiera for Shaken Baby Prevention education.
- Supporting rural public health nurses via telephone education sessions.

EXAMPLES OF CHANGE ACTION LEARNING INCLUDED:

- Referral rates did not improve following implementation of an antenatal MDT, but report of concern quality improved.
- Family violence intervention coordinator ward visits did not improve IPV enquiry in maternity services.
- Child protection checklist postcard prompts did not significantly increase completion rates.

Summary

VIP 2019 evaluation data indicate system infrastructure is in place to support health professionals to respond to those impacted by violence. However, the domains which involve the practice of intervening (VIP Practices) and the monitoring of intervention effectiveness (Quality Improvement) remain low performing. This finding is reinforced by clinical snapshots continuing to evidence high variation in the quality and consistency of IPV and CAN assessment and disclosure across services and DHBs. In 2019, 14 of 130 VIP service locations evidenced reaching the service target zone, an achievement rate of 11%. Urgent work is needed to improve VIP assessment and disclosure rates, critical for identifying and reducing the health impacts of violence.

VIP Priorities:

- Undertake urgent work to improve VIP assessment and disclosure rates. This will involve innovative inquiry to understand health professional experiences of engaging with those impacted by violence as well as service user experiences of the VIP intervention.
- Support the development of collaborative and reciprocal partnerships with Māori to inform and improve VIP policy and practice.
- Review VIP programme logic to align with current cross-government work on integrating family violence systems.

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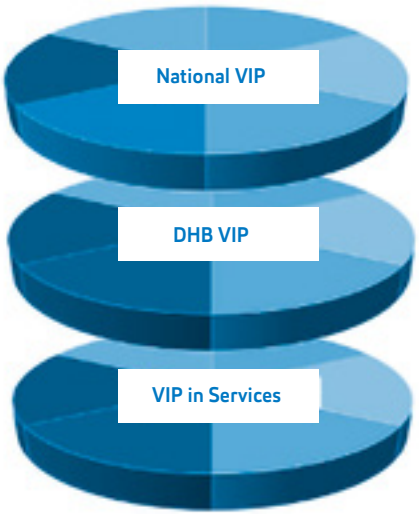
INTRODUCTION

Internationally and within New Zealand, family violence is acknowledged as a human rights violation and a preventable public health problem that impacts significantly on women, children, whānau and communities.[6,13-16] Early identification of people subjected to violence followed by a supportive and effective response can improve safety and wellbeing.[6] The health care system is an important point of entry for the multi-sectoral response to family violence, including both preventing violence and treating its consequences.[17,18]

The Ministry of Health ('the Ministry') began the Family Violence Health Intervention Project in 2001 (see Appendix A) and launched the renamed Violence Intervention Programme (VIP) in 2007. VIP seeks to reduce and prevent the health impacts of violence and abuse through early identification, assessment and referral of victims presenting to targeted health services. This programme provides the resources for the health sector response, which is one component of the multi-agency approach to reduce family violence in New Zealand. Strategically aligned with the Ministry's Statement of Intent 2017-2021[19], the VIP programme is ideally placed to respond to new legislation and future family violence and sexual violence cross-government joint venture work programme initiatives.[3]

FIGURE 1: TIERS OF THE MULTIFACETED SYSTEMS OF VIP



The national VIP management team have identified system infrastructure supports involving the interaction between three tiers: the national framework, DHBs and at the point of service delivery (see Figure 1)[20]. Each tier encompasses the six system components outlined below (see Figure 2).

VIP is premised on a standardised, comprehensive systems approach[6,8] supported by six programme components funded by the Ministry (Figure 2). These components include:

- DHB Family Violence Intervention Coordinators (FVIC)
- MOH Family Violence Intervention Guidelines (2002, 2016)
- Resources that include a MOH family violence website, a VIP section on the Health and Innovation Resource Centre (HIIRC) website, posters, cue cards, pamphlets, policy and procedure templates, and the VIP quality improvement toolkit
- National technical advice and support provided by a VIP Manager, VIP Training and family violence intervention coordinator meetings
- National training contracts for VIP target service staff and primary care providers
- Monitoring and evaluation of VIP target service family violence responsiveness

FIGURE 2: MINISTRY OF HEALTH VIP SYSTEMS SUPPORT MODEL (DHBS)

This report documents the results of three evaluation work streams.

Firstly, DHB programme inputs (system infrastructure) are assessed at the DHB level against criteria for an ideal programme using a Delphi tool.[21–23] The quantitative Delphi scores provide a means of monitoring infrastructure across the 20 DHBs over time. This work stream calls attention to areas in which systems are high performing as well as areas requiring additional support.

Secondly, programme service delivery is measured by VIP Snapshot clinical audits. VIP Snapshots measure women and children assessed for violence and abuse and women and children with a violence concern who receive specialist assistance. Snapshots conducted in New South Wales proved useful in monitoring service delivery. Over the past four years, NSW snapshot data has evidenced steady progress in identifying and screening women experiencing violence and providing referral and support.[24] The snapshots provide accountability data and the ability to monitor the effect of system changes over time.

Thirdly, Model for Improvement Plan–Do–Study–Act (PDSAs)[12] worksheets are part of the evaluation process as a quality improvement initiative. DHBs complete two PDSA cycles focused on improving DHB IPV routine enquiry and disclosure rates, CAN child protection assessment and concern rates or reducing inequities for Māori.

This evaluation report provides practice-based evidence of the current Violence Intervention Programme inputs, outputs and outcomes (Figure 3). Together, the Delphi infrastructure, snapshot audits and quality improvement information deliver data to services, DHBs, MOH, the VIP management team and other key government departments involved in reducing violence within families or whānau. It also contributes to government priorities on protecting vulnerable children and Whānau Ora.[3,25–26]

In this report we present the VIP evaluation data for the period 1 July 2018 – 30 June 2019, including historical data for analysis of trends over time. Evaluation data (a) measures programme infrastructure indicators, (b) measures service delivery consistency and quality in MOH targeted services, and (c) fosters system improvements.

This evaluation sought to answer the following questions:

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

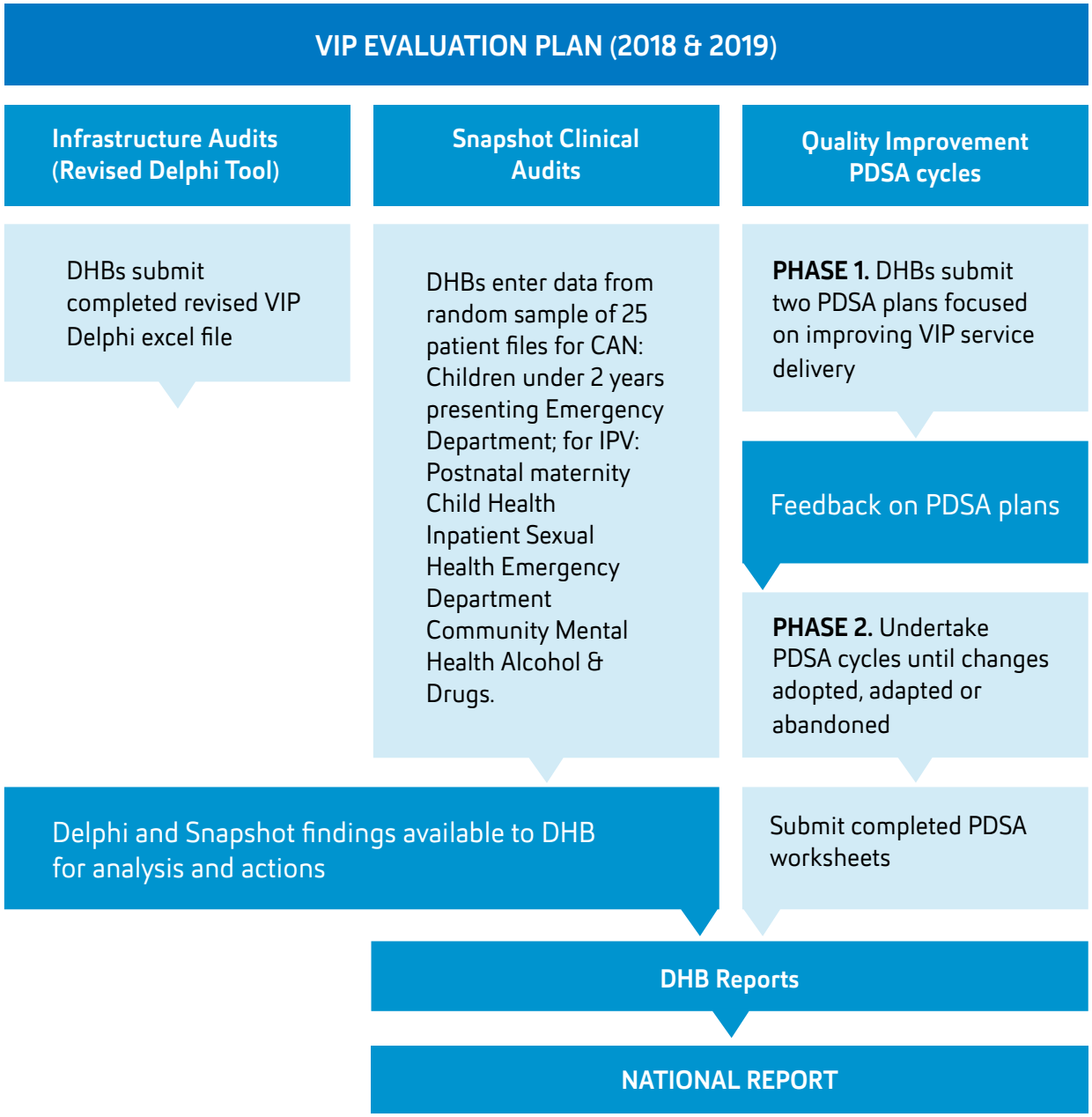
METHODS

Ministry of Health contracts with DHBs specify participation in the evaluation process. All 20 DHBs participated in the 2019 VIP evaluation (Appendix B). The evaluation project is approved annually by the Multi-Region Ethics Committee (AKY/03/09/21/AM10), most recently on 29 February 2020.

Evaluation procedures are based on a philosophy of supporting programme leaders in building a culture of improvement.[12,27] Details of evaluation processes are outlined in Figure 3 and Appendix C. The 2019 VIP Programme evaluation commenced on 05 September 2019 with a letter from the Ministry advising DHBs of the upcoming audit round sent to all DHB VIP Portfolio and Service Managers. On 05 September 2019, the AUT Evaluation Team advised DHBs of the audit requirements for the 2019 VIP programme evaluation. Evaluation data was due from DHBs on 04 October 2019.

DHBs completed their evaluation data (submitting Delphi infrastructure self-audit file, completing online snapshot clinical audits and submitting PDSA plans) between 17 September 2019 and 6 November 2019. The interactive files allows users to see measurement notes, enter their indicator data and instantly receive their scores to inform improvement planning. Following review of all DHB evaluation data, the evaluation team provided individual DHB reports to the DHB CEO, copied to the DHB VIP portfolio manager and the Ministry.

FIGURE 3. 2019 VIP EVALUATION PLAN (NOTE: PDSA = PLAN, DO, STUDY, ACT)



System infrastructure audit

Scaling up a quality, sustainable health response to family violence is reliant on quality systems.[4–10, 28] DHBs were invited to submit VIP Delphi tool (revised) self-audit data covering the one-year period 1 July 2018 to 30 June 2019.

A panel of experts developed the revised tool in 2017 to identify elements of an ideal programme. The tool combines the previous IPV and CAN audit tools into one, reducing audit burden and reflecting an integrated response to IPV and CAN. Fifty-eight performance measures are categorised into nine domains (Table 1) reflecting components consistent with a systems model approach. Recognising that culturally responsive health systems contribute to reducing health inequities, the revised VIP Delphi tool includes a specific Cultural Responsiveness domain.

The audit tool is available (open access at www.aut.ac.nz/vipevaluation) as an interactive excel file. The tool is to be completed by DHB Family Violence Intervention Coordinators (FVIC) and/or the VIP manager, with two domains and some further items to be completed by the most senior manager responsible for the VIP (e.g. the VIP Sponsor). The interactive file allows users to see measurement notes, enter their indicator data and instantly receive their scores to inform improvement planning.

Each Delphi domain score is standardised, resulting in a possible score from 0 to 100 with higher scores indicating greater levels of programme development. An overall score is generated using a weighting scheme (see Table 1). Self-audit data were exported from Excel audit tools into R (version 3.6.2). Score calculations were confirmed between Excel and R. In this report, we present overall and domain scores

TABLE 1: REVISED VIP DELPHI TOOL DOMAINS AND SCORING WEIGHT

Domain (number of items)	Definition	Weight
Organisational leadership (9)	Ownership, leadership and support evidenced through participation, communication and connection	14
Training and support (8)	Staff receive the appropriate training, reinforcement and support to effectively implement VIP	11.8
Resource funding (2)	VIP funding is fully allocated, supporting continuous and sustained coordinator(s), with dedicated cultural resources	11.5
VIP practices (7)	Intervention services follow the MoH Family Violence Assessment and Intervention Guideline procedures and are implemented at all levels of the DHB	11
Cultural Responsiveness (7)	Includes education, support and services informed by people's diverse needs: Māori, multicultural, disabled and gender identity when living with family violence	10.9
Quality improvement (9)	Strategic and continuous monitoring to ensure effective programme delivery	10.8
Policies and procedures (5)	Policies and procedures exist, are reviewed, aligned to guidelines and legislation, and are culturally responsive	10.6
Collaboration (6)	Internal and external collaboration throughout programme and practice	10.5
Documentation (3)	Standardised documentation tools are easily accessible, aligned with the MoH Guideline, and are used to record known or suspected cases of family violence	8.8
Total (56)		**100**

and call attention to specific individual indicators. We demonstrate central tendency and spread using boxplots. See Appendix D for how to interpret box plots.

Snapshot clinical audit

The snapshot clinical audits aim to collect 'accountability data that matter to external parties' [11] and use a nationally standardised reporting process to monitor service delivery and inform performance improvements.[29]

Snapshot audits provide estimates of: (a) VIP outputs – women and children assessed for violence and abuse and (b) VIP outcomes – women and children with a violence concern who received specialist assistance. Specialist assistance includes both active and passive referrals. Active referrals generate timely access to support from a family violence trained specialist, such as a social worker, family violence advocate or police.

The inaugural VIP snapshots occurred in 2014 and included two designated services, with a further two services added for the 2015 and 2016 evaluations respectively.

Selected Services

The snapshot clinical audits in 2019 included six services for IPV enquiry and intervention and one service for child abuse and neglect assessment and intervention (see Table 2). Across all DHBs, ten service locations are either contracted to an NGO, not provided by the DHB, or amalgamated within another service or regionally.

TABLE 2: SNAPSHOT CLINICAL AUDIT ELIGIBLE SERVICES

Intimate Partner Violence (IPV)	# of services	Child Abuse and Neglect (CAN)	# of services
Postnatal maternity (in-patient)	20	Emergency department (children under two years of age presenting for any reason).	20
Child health (in-patient)	20		
Sexual health	15		
Emergency department (adult)	20		
Community alcohol and drug	15		
Community mental health (adult, general)	20		
Total number of eligible services for clinical audit snapshot reporting	**110**		**20**

Targets

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

- System reliability is achieved when a standard action occurs at least 80% of the time.[30] Therefore, VIP aims to achieve IPV and CAN assessment rates ≥80%
- Based on the prevalence of CAN indicators (such as CAN alerts), VIP expects the rate of child protection concern identification to be ≥ 5%.
- The quality of IPV routine enquiry (screening) influences women's decision whether or not to disclose IPV to a health worker.[31-32] The estimated New Zealand population past year IPV prevalence rate among women is ≈ 5%.[33-34] The prevalence of IPV reported by women receiving health care services is higher than the population prevalence in both international and New Zealand research.[35-39] This is not surprising given the negative impact of IPV on health.[40]
- Several years of snapshot clinical audit data demonstrate a pattern of consistently higher disclosures in some services over time. In 2019 the IPV disclosure rate target was revised in all services except postnatal maternity (see Table 3). The targets were informed by research literature and historical snapshot data, rounding of the 70th percentile (allowing for diversity in social determinants of health among DHB populations) among those reporting at least a 30% assessment rate.

Eligibility and Sampling

Snapshot eligibility criteria are aligned with The Guideline[2] recommendations for assessment across different settings. For example, in the emergency department, adult women should be assessed at every visit; in mental health settings, adult women should be assessed at the 'initial assessment' and annually. Table 4 lists the VIP Snapshot eligibility criteria (see also Appendix C).

TABLE 3: SNAPSHOT TARGETS FOR IPV DISCLOSURE AND CAN CONCERN

	Pre-2019 Target	2019 Target
IPV Disclosure Rates		
Postnatal maternity	5%	5%
Child Health In-patient	5%	10%
Alcohol and Drug	5%	25%
Emergency Department	5%	15%
Sexual Health	5%	15%
Community Mental Health	5%	25%
CAN Concern Rates		
Emergency Department	5%	15%

Note: The 2018 evaluation report published an Alcohol and Drug service target of 15% for 2019. However, upon review of historical snapshot data and research literature, a 25% target is appropriate for 2019.

TABLE 4: SNAPSHOT ELIGIBILITY CRITERIA FOR DESIGNATED SERVICES

Service	Eligibility criteria
Child abuse and neglect	
Emergency Department	All visits by children under the age of two years who present to an emergency department (for any reason) during the audit period
Intimate partner violence	
Postnatal Maternity	Any woman who has given live birth and been admitted to postnatal maternity ward during the audit period
Child Health In-patient	The female caregiver (guardian, parent or caregiver) of any child aged 16 and under admitted to a general paediatric inpatient ward (not a specialty setting) during the audit period
Alcohol and Drug	New women clients (seen for the first time by the service) and previous women clients (discharged and re-referred to service) aged 16 years and over who presented to Community Alcohol and Drug Services during the audit period
Emergency Department	All visits by women aged 16 years and over who present to an emergency department during the audit period
Sexual Health	All women aged 16 years and over who present to sexual health services during the audit period
Community Mental Health	New women clients (seen for the first time by the service) and previous women clients (discharged and re-referred to service) aged 16 years and over who presented to adult general Community Mental Health Services during the audit period.

The Snapshot sampling process begins with identifying the population (sampling frame) of eligible visits during the three-month period (1 April – 30 June) within each DHB, for each designated service. Then, from the sampling frame, a random sample of 25 records are selected for review. For services expecting assessment at every visit (e.g. emergency department), women with multiple visits during the audit time period could be included in the sample more than once. Programmes were advised to seek assistance in eligibility and sampling processes from their Quality Manager, Clinical Records or Information Specialists. They were also referred to the VIP Toolkit document entitled 'How to select an audit sample'. Once the records are retrieved (electronic or hard copy), DHB VIP staff or delegates retrospectively reviewed the selected records and entered the data in the confidential web-based VIP snapshot reporting system.

Most DHBs audited their single 'main site' (tertiary hospital and most urban community service location). This meant that the Snapshot audit involved each DHB reviewing 175 clinical records. Some DHBs elected to enter independent samples from two service locations (Appendix B).

Data Elements

The following variables were collected for each randomly selected case (see record review instructions and definitions in Appendix C)

- DHB, site and service
- Total number of eligible visits (by women, or child, depending on service) in the designated service during the three-month audit period 1 April to 30 June (this is the sampling frame)
- Proportion of staff (e.g. doctors, nurses, midwives, social workers) in designated services who have received the national VIP training
- Ethnicity – up to three ethnicities per patient are recorded, consistent with MOH standard[41]
- Child age, ranging between 0–16 years (for child health in-patient services only)
- Adult age and triage status (for adult emergency department only)
- IPV variables:
    - IPV screen (Yes/No)
    - IPV disclosure (Yes/No)
    - IPV referral (active (onsite), passive (offsite), or none)
- CAN variables:
    - Child protection risk assessment (Yes/No)
    - Child protection concern identified (Yes/No)
    - Child protection consultation (Yes/No)

Analysis

Collected from the secure web-based server using Microsoft Excel, a descriptive analysis of each snapshot data element was conducted using R (version 3.6.2). National mean assessment rates and 95% confidence intervals were calculated using individual DHB rates weighted by the number of eligible visits or clients presenting to each VIP service during the audit period. Data were then extrapolated to provide national estimates of the number of health clients who received VIP assessment. Identification of child protection concern and disclosure of IPV, along with consultation and referral rates were calculated similarly. Dumbbell plots are used to visualise differences by services or over time (see Appendix E for how to interpret Dumbbell plots).

The electronic VIP snapshot reporting system provides service results and a graph on completion of the input for each service, providing timely feedback to services. An overview of VIP snapshot data was presented to the National Network of the Violence Intervention Programme in November 2019 to review data interpretation and inform national VIP planning.

Quality improvement (Plan–Do–Study–Act cycles)

The Model for Improvement Plan–Do–Study– Act (PDSA) cycle was introduced into the evaluation activities of the VIP programme in 2015. The Model for Improvement[12] is a simple framework to guide specific improvements in personal work, teams or natural work groups. The model comprises three basic questions:

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in an improvement?

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

Two PDSA plans were requested to be submitted for feedback by the AUT evaluation team prior to implementation (i.e. writing the PLAN phase before undertaking the DO, STUDY and ACT phases). They were directed to be aimed at improving service delivery using the snapshot audit results. PDSA cycles were to improve rates of family violence assessment or specialised consultation, or cultural responsiveness for Māori. A PDSA pack (including a template, resource and instructions) was distributed and ongoing support, coaching and feedback was provided by the evaluation team. DHBs were to submit two PDSA plans to evaluators by 4 October 2019. The evaluation team then provided PDSA plan feedback. Completed PDSA worksheets were to be submitted by 10 December 2019.

FINDINGS

SYSTEM INFRASTRUCTURE

Overall Score

Across the 20 DHBs, the 2019 overall VIP infrastructure score ranged from 45 to 91. The typical (median) score was 80, an increase from 71 in 2018 (Figure 4). Fifty percent of DHBs achieved the target score of 80 in 2019. The spread of scores are shown in Figure 5, with DHBs anonymised. Individual DHB change scores (2019 – 2018) ranged from 0 (no change) to an increase of 22.

FIGURE 4: OVERALL DHB SYSTEM INFRASTRUCTURE SCORES 2018 AND 2019

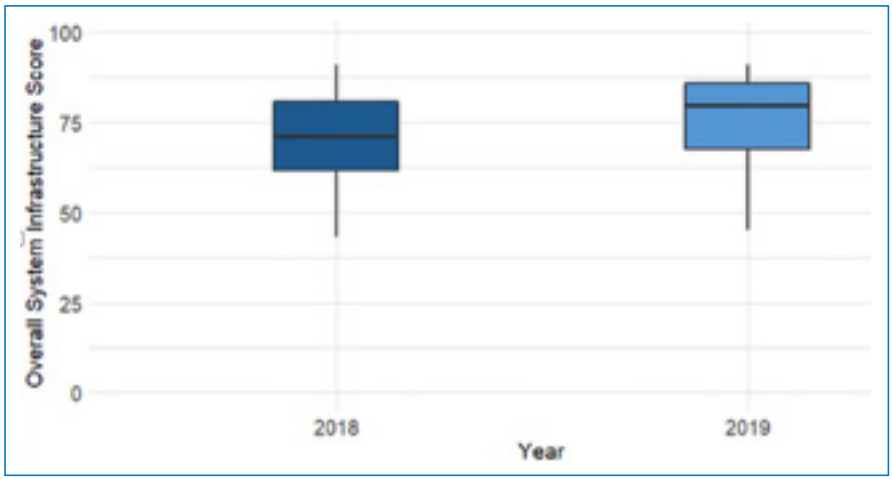


FIGURE 5: 2019 DHB SYSTEM INFRASTRUCTURE LEAGUE TABLE

DHB	2019 Score	Target (80)	Change from 2018
A	91		0
B	91		11
C	91		1
D	90		7
E	88		3
F	85		1
G	84		12
H	81		12
I	80		5
J	80		3
K	79		1
L	78		22
M	71		9
N	70		0
O	68		12
P	66		2
Q	65		1
R	61		0
S	57		3
T	45		2
DHB Median	80		9

Domains

Infrastructure domain scores are provided in Figure 6 and Table 5. Individual programme indicator frequencies are listed in Appendix F.

DHBs continue to perform consistently high in *Policies and Procedures* (median = 100) and Documentation (median = 100). 2019 scores increased compared to 2018 scores in six domains. The *VIP Practices* score remained unchanged and is the lowest performing domain (median = 57). The largest improvement was made in *Quality Improvement*, increasing by 20 points, yet the domain continues to be low performing with wide variation amongst DHBs (median = 70).

Domains which involve the practice of intervening (*VIP Practices*) and the monitoring of intervention effectiveness (*Quality Improvement*) remain areas for support and development. This is consistent with clinical snapshot data continuing to reflect high variation in the quality and consistency of IPV and CAN assessment and disclosure across services and DHBs. As in 2018, the *VIP Practices* domain shows only three DHBs (15%) complete a child protection checklist for at least 95% of children under the age of two that present to the emergency department (*VIP Practices* domain indicator 4).

In *Quality Improvement*, only eight DHBs (40%) include VIP within the DHB quality and risk strategic plan (*Quality Improvement* domain indicator 1). While 13 DHBs report having a VIP quality improvement plan, only ten (50%) report regularly gathering patient, client or community feedback to inform VIP service delivery (*Quality Improvement* indicators 2 and 6). While use of a Māori quality framework to evaluate service delivery for Māori along with Māori Health Unit review of recommendations for improvement have increased since 2018, at least half of DHBs have yet to implement these processes (*Quality Improvement* indicators 8 and 9). This is also reflected within the *Cultural Responsiveness* domain where Māori-led evaluation of VIP service delivery takes place within only four (20%) DHBs (*Cultural Responsiveness* indicator 5).

VIP INFRASTRUCTURE DOMAINS

HIGH PERFORMANCE (≥ 80)
Policies & Procedures
Collaboration
Documentation

MEDIUM PERFORMANCE (≥50 - <80)
Organisational Leadership
Training and Support
Resource Funding

LOW PERFORMANCE (<50)
Quality Improvement
VIP Practices

FIGURE 6: 2019 VIP INFRASTRUCTURE DOMAIN SCORES

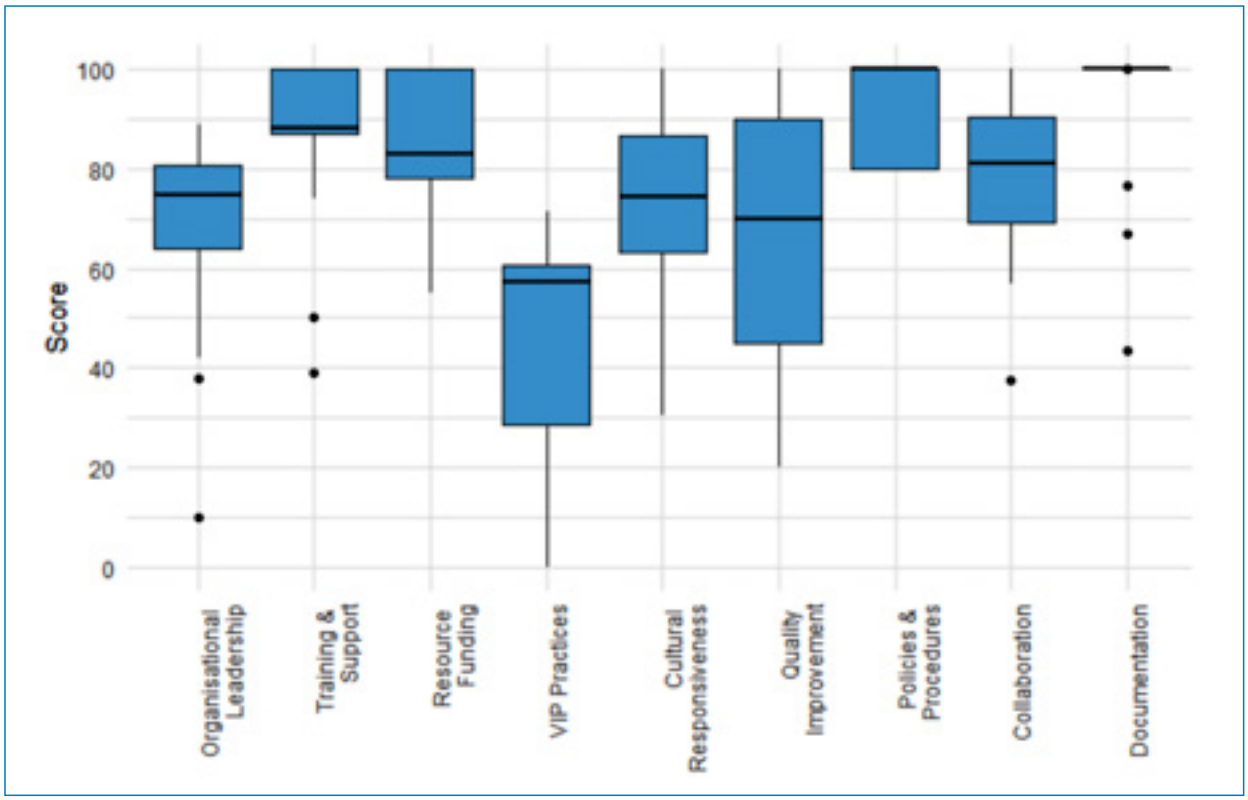


TABLE 5: DELPHI DOMAIN ANALYSIS

Domain	Weight	Number of Items	Min		Max		Interquartile range		Median		Median change score (2019-2018)
			2018	2019	2018	2019	2018	2019	2018	2019	
Organisational Leadership	14.0	9	8	10	87	89	23	17	68	75	+7
Training and Support	11.8	8	48	39	100	100	26	13	87	88	+1
Resource Funding	11.5	3	46	55	100	100	13	22	78	83	+5
VIP Practices	11.0	8	0	0	71	71	32	32	57	57	0
Cultural Responsiveness	10.9	7	35	30	93	100	17	24	66	74	+8
Quality Improvement	10.8	10	10	20	100	100	50	45	50	70	+20
Policies and Procedures	10.6	5	60	80	100	100	0	20	100	100	0
Collaboration	10.5	5	38	38	100	100	21	22	74	81	+7
Documentation	8.8	3	43	43	100	100	3	0	100	100	0
Overall		58							71	80	+9

FINDINGS

SNAPSHOT CLINICAL AUDITS

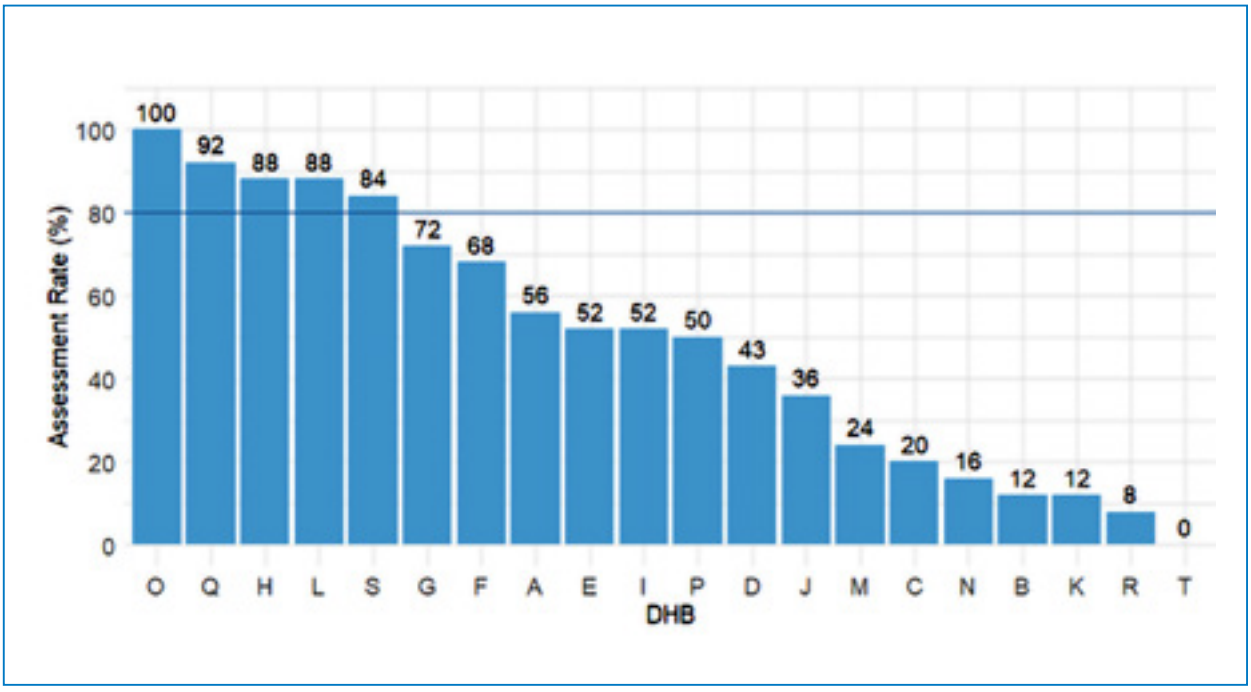
Child abuse and neglect assessment and intervention

DHB Results

In 2019, the 20 DHBs provided data from 20 emergency departments (ED). They recorded 16,812 visits by children under two years presenting for any reason to ED during the three month period (1 April – 30 June). Random sampling from the 20 locations included 530 ED visits audited for the 2019 CAN snapshot (one DHB reported from two hospitals and one DHB sampled 30 records).

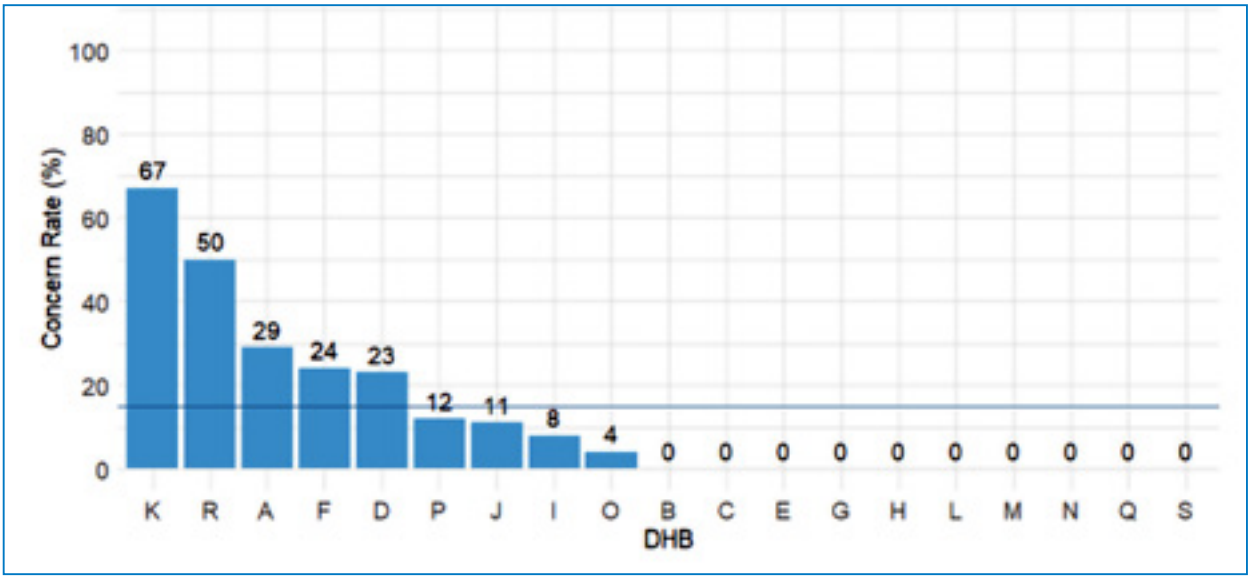
Across DHBs, **child abuse and neglect assessment** rates for visits by children under two years presenting to ED for any reason ranged from 0% to 100% (Figure 7; Appendix G). Five DHBs (Auckland, Capital & Coast, Hutt Valley, Nelson Marlborough and Waitemata) achieved the target assessment rate of ≥ 80%.

FIGURE 7: DHB EMERGENCY DEPARTMENT 2019 (APRIL – JUNE) CHILD ABUSE AND NEGLECT ASSESSMENT RATES FOR CHILDREN PRESENTING UNDER 2 YEARS OF AGE (N=20)



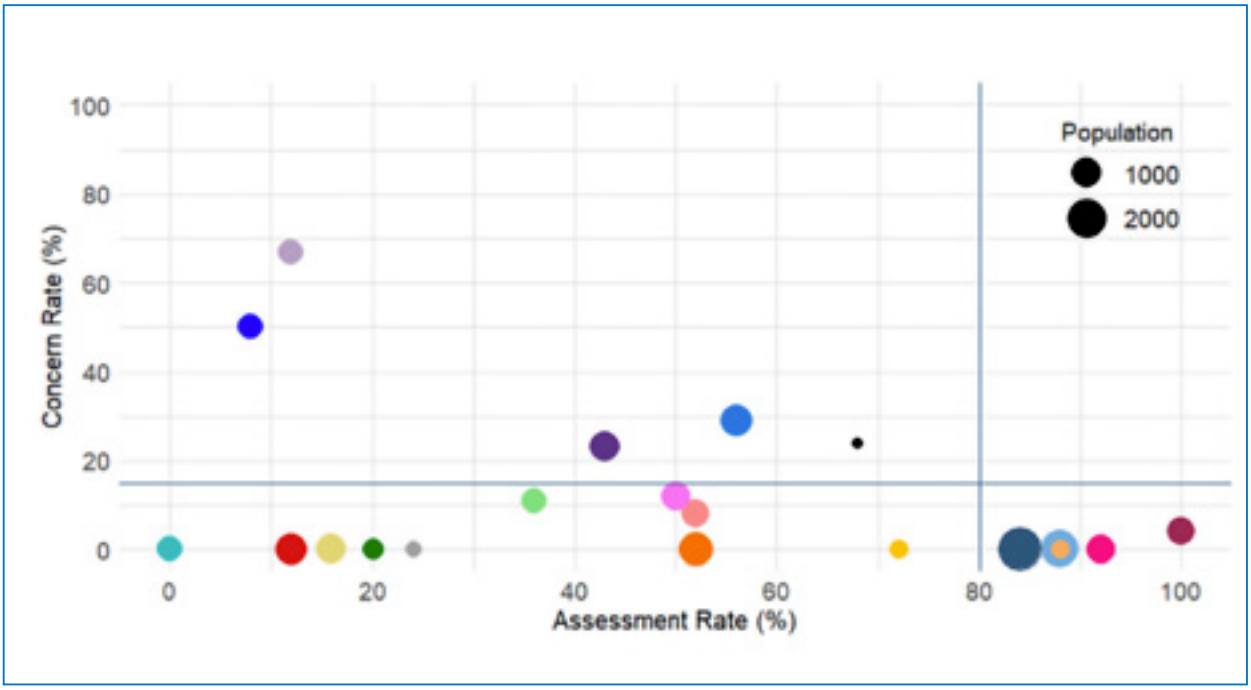
DHB rates of identifying a **child protection concern** among those assessed ranged from 0% to 67% (Figure 8). Nine DHBs had a non-zero child protection concern rate, of which five (Bay of Plenty, Lakes, Taranaki, West Coast and Whanganui) met the child protection target rate of ≥ 15% (Figure 8; Appendix G). In DHBs that identified child protection concerns, the rate of **specialist consultation** among children with a concern, ranged from 0% (in one DHB) to 100% (achieved in seven of the nine DHBs).

FIGURE 8: DHB EMERGENCY DEPARTMENT 2019 (APRIL – JUNE) CHILD PROTECTION CONCERN RATES AMONG CHILDREN UNDER 2 YEARS WHO RECEIVED A CHILD PROTECTION ASSESSMENT (N=19)



The association between assessment and concern rates is shown in Figure 9. No DHBs achieved the target rates of ≥ 80% child protection assessment and ≥ 15% concern. With the variability in assessment rates, it is difficult to know to what extent the concern rates reflect population variation or are due to bias.

FIGURE 9: DHB EMERGENCY DEPARTMENT 2019 (APRIL – JUNE) CHILD ABUSE AND NEGLECT ASSESSMENT AND CONCERN RATES FOR VISITS BY CHILDREN UNDER 2 YEARS



Note: Bubble size refers to the total number of eligible patients admitted to the children's emergency department of each DHB. Some points include more than one DHB.

National Estimates

Assessment. Among emergency department visits by children under two years of age during the three month audit period (April – June 2019) we estimate:

- 55% included a child protection assessment. This is the highest recorded rate across the five Snapshot audits (2014–2019).
- Nationwide, approximately nine thousand (9,308) visits by children included a child protection assessment during the 2019 audit period (Figure 10 and Appendix G).

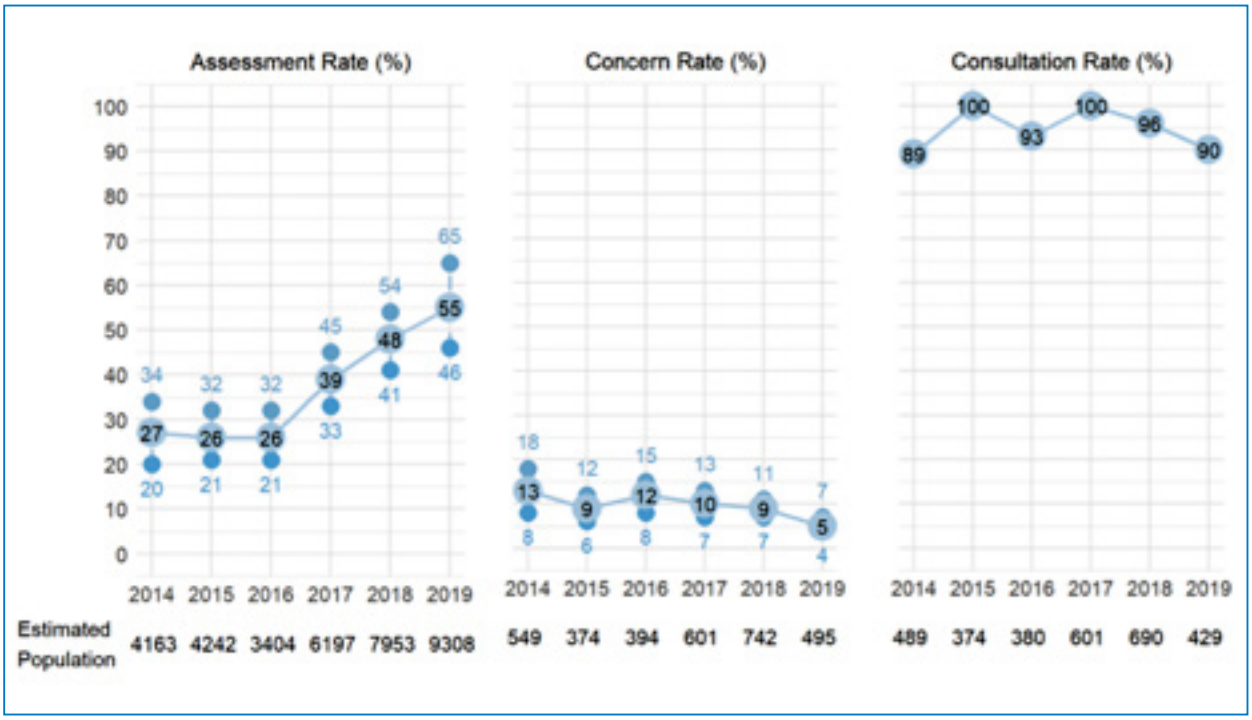
Concern. Among visits by children under two years of age who presented to an emergency department during the three month audit period (April – June 2019) and were assessed for child protection:

- A child protection concern was noted for 5%. This is the lowest concern rate recorded across the five Snapshot audits (2014–2019).
- Nationwide, we estimate a concern about safety was identified in 495 visits by children during the 2019 audit period (Figure 10 and Appendix G).

Specialist Consultation. Among visits by children under two years of age who presented to an emergency department during the three month audit period in which a child protection assessment indicated a concern:

- 90% of children received specialist consultation. Over the five Snapshot audits, this rate has varied between 89% (2014) and 100% (2017).
- Nationwide, we estimate 429 visits by children included specialist consultation for a child protection concern during the 2019 audit (Figure 10 and Appendix G).

FIGURE 10: DHB EMERGENCY DEPARTMENT CHILD ABUSE AND NEGLECT ASSESSMENT, CONCERN AND CONSULTATION RATES FOR CHILDREN UNDER TWO YEARS OF AGE 2014–2019 (APRIL – JUNE PERIOD)



Note: Error bars represent 95% confidence intervals.

Intimate partner violence assessment and intervention

National Overview

In 2019, 20 DHBs provided Intimate Partner Violence (IPV) service delivery data from 109 service locations. This section provides an overview of results across vip services, findings are visualised in Figure 11 and provided in Appendix H.

Assessment. During the three month audit period (April – June 2019):

- The proportion of eligible women's visits that included an IPV assessment ranged between 28% in the emergency department (95% CI 24, 31) to 75% in sexual health services (95% CI 68, 82).

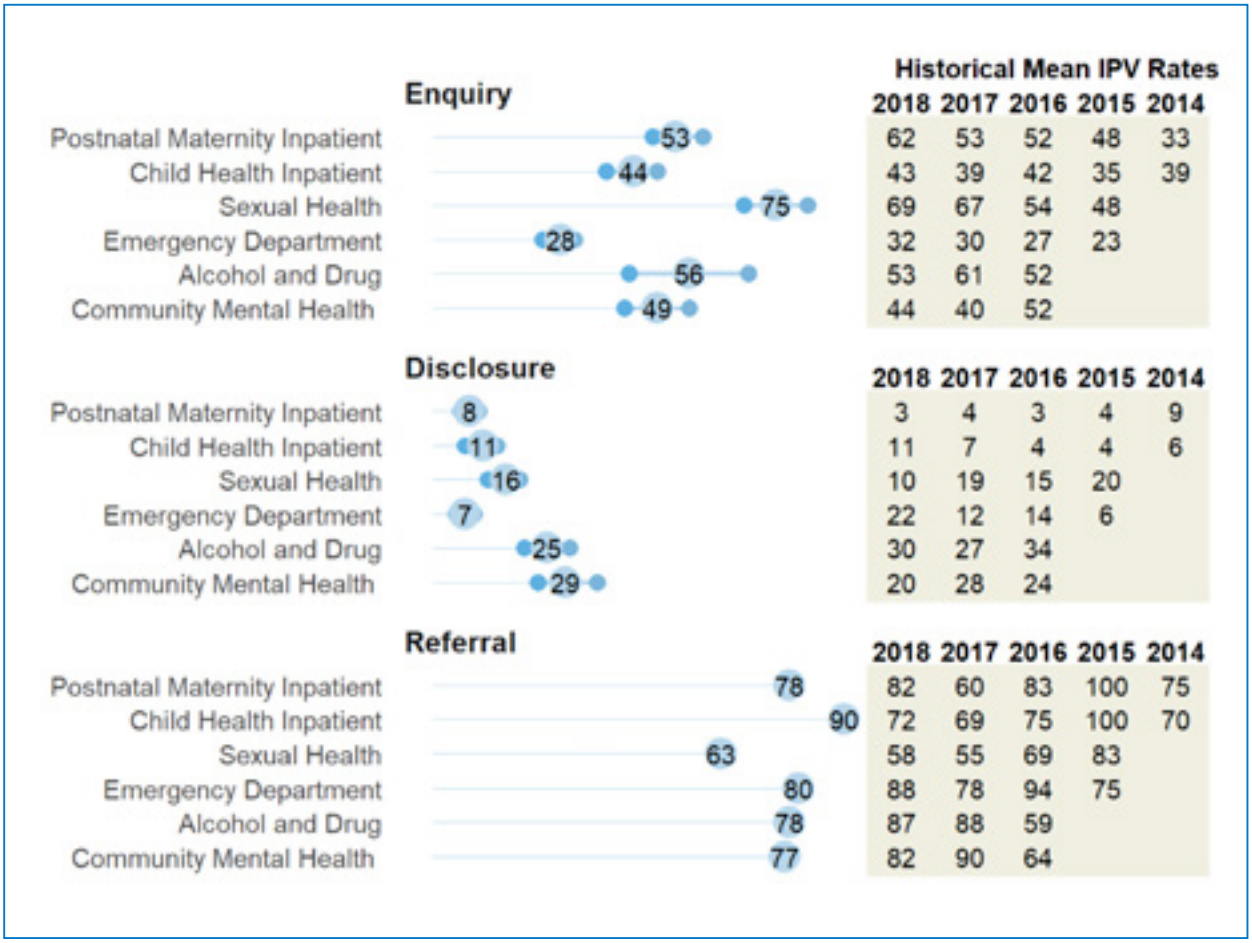
Disclosure. During the three month audit period (April – June), among visits by women assessed for IPV:

- The proportion of visits in which women disclosed IPV ranged from 7% in the emergency department (95% CI 5, 9) to 29% in community mental health services (95% CI 23, 36).
- Nationwide, during the three month audit period, we estimate approximately 5,290 visits by women included a disclosure of IPV to a health worker across the six targeted services. This is a decrease of 4,599 disclosures estimated in 2018, largely attributable to a substantial decrease of disclosures in emergency departments.

Referral. During the three month audit period (April – June), in visits among women who disclosed IPV:

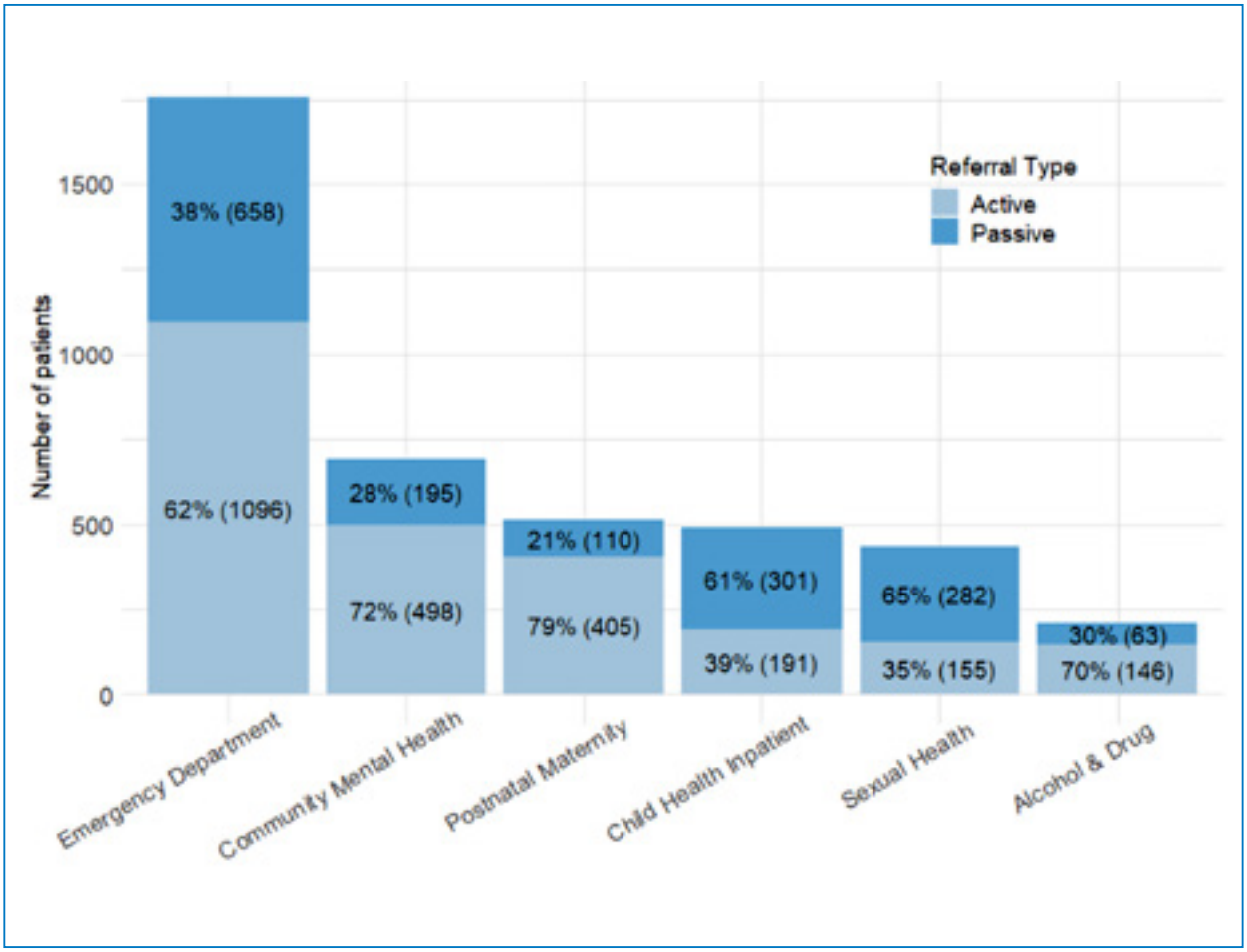
- The proportion of women who received a specialist referral ranged from 63% in the sexual health services to 90% in child health in-patient services.
- Nationwide, we estimate approximately 4,100 visits by women who disclosed IPV to their health worker included a specialist referral.
- Low disclosure rates reduced the number of women who were provided access to specialist services in 2019 compared to 2018 (from 4,574 to 4100).
- National estimates indicate that most women who received a specialist family violence intervention in 2019 during the three month audit period were referred through the emergency department (n=1,754) and community mental health (n=693) (Figure 12). These services have IPV disclosure rates greater than 5%. In addition, the emergency department has high patient volumes.
- A high proportion of referrals were active (timely, onsite) in postnatal maternity (79%), alcohol and drug (70%) and community mental health services (72%) (Figure 12).

FIGURE 11: NATIONAL ESTIMATES OF THE PROPORTION OF WOMEN WHO RECEIVED INTIMATE PARTNER VIOLENCE ASSESSMENT AND INTERVENTION ACROSS DHB SERVICES (APRIL – JUNE 2014–2019)



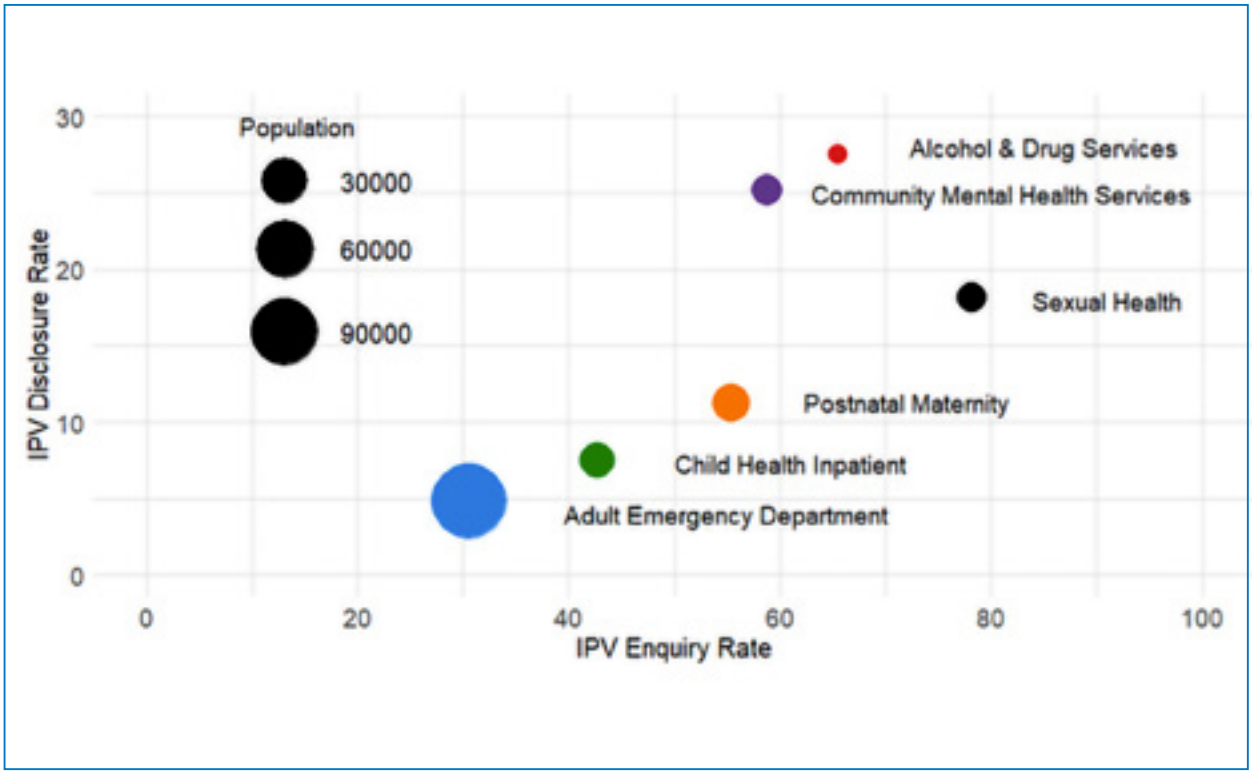
Note: Error bars represent 95% confidence intervals.

FIGURE 12: NATIONAL ESTIMATES OF WOMEN RECEIVING ACTIVE OR PASSIVE SPECIALIST IPV REFERRALS BY SERVICE (APRIL–JUNE 2019)



National IPV snapshot rates did not meet the assessment and disclosure target zone for any of the six services in 2019 (Figure 13). Average assessment and disclosure rates mask variability in service delivery. In 2019, 14 service locations reached the target zone (see Table 6). These achieving services were located across 8 DHBs. Based on the possible 110 eligible IPV VIP service locations (see Table 2), the rate of achieving the target was 13%. In the following sections we provide service-specific detail.

FIGURE 13: NATIONAL AVERAGE (WEIGHTED) INTIMATE PARTNER VIOLENCE ROUTINE ENQUIRY AND DISCLOSURE RATES (APRIL – JUNE) 2019 BY SERVICE



Note: Bubble size refers to the total number of eligible patients admitted to each department.

TABLE 6: DHB SERVICES ACHIEVING INTIMATE PARTNER VIOLENCE ASSESSMENT (>80%) AND IDENTIFICATION TARGET RATES BASED ON SNAPSHOT DATA (APRIL – JUNE 2019)

Service	Disclosure target	Auckland	Bay of Plenty	Canterbury	Capital & Coast	Counties Manukau	Hawkes Bay	Hutt Valley	Lakes	Midcentral	Nelson Marlborough	Northland	South Canterbury	Southern	Tairawhiti	Taranaki	Waikato	Wairarapa	Waitemata	West Coast	Whanganui	Total target achieved
Acute services																						
Postnatal Maternity	5%																					1
Child Health In-Patient	10%																					2
Emergency Department	15%																					0
Community services																						
Sexual Health	15%				NA	NA		NA										NA	NA			5
Community Mental Health	25%								NS													3
Community Alcohol & Drug	25%	NA				NA		NA	NA									NA				3

Table Legend

Dark blue	Target met	≥ 80% assessment and service specific disclosure rate
Light blue	Target 'almost' met	Within 10% assessment rate and within 5% of disclosure rate (within 3% of disclosure rate for Postnatal Maternity)
NA	Not applicable	DHB does not provide service (contracts out or regional)
NS	Data not submitted	

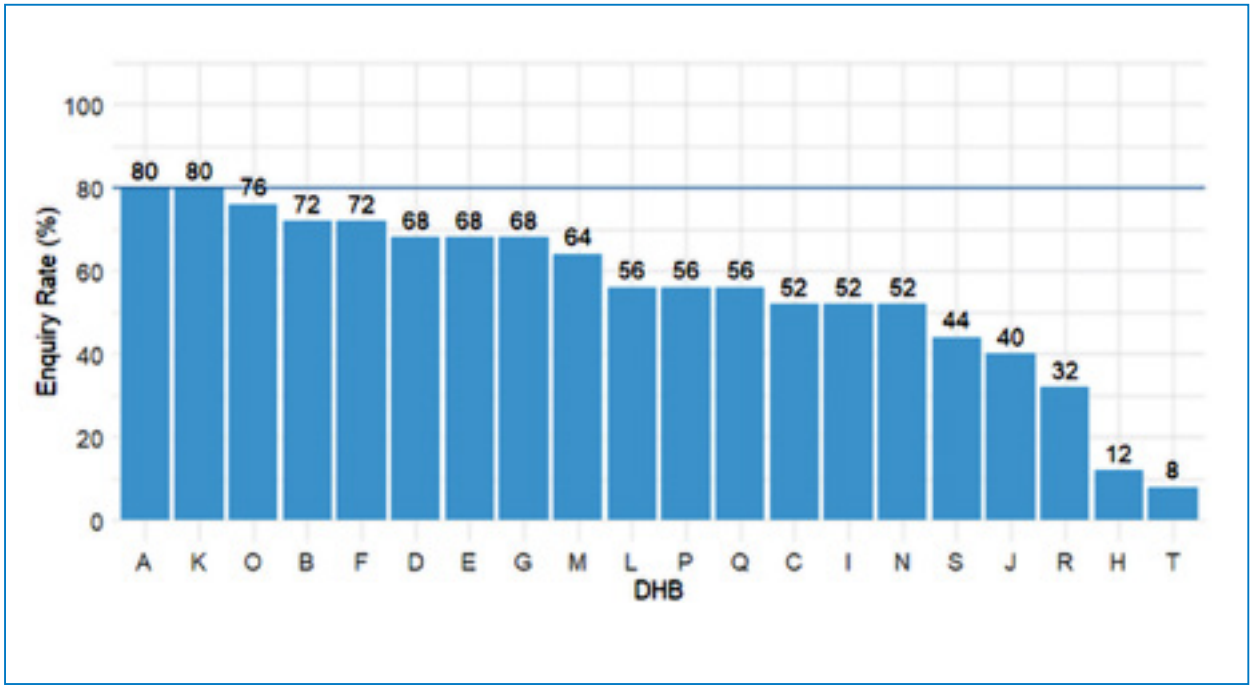
Post-Natal Maternity

DHB Results

Across the 20 DHBs, 13,384 women were admitted to post-natal maternity services during the three month audit period (April – June). Random sampling from the 20 locations resulted in 525 cases (one DHB provided data from two hospital sites) audited for the 2019 snapshot (see Figure 17).

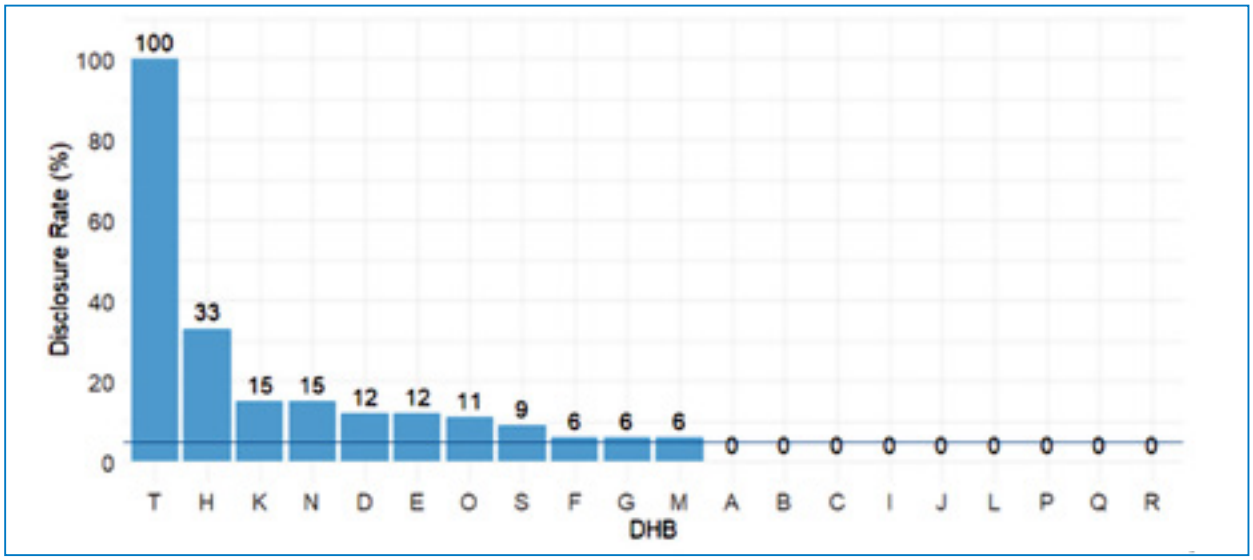
VIP post-natal routine **assessment rates** ranged from 8% to 80%. Two DHBs (Bay of Plenty and Taranaki) achieved the target IPV routine assessment rate of ≥ 80% (Figure 14).

FIGURE 14: DHB POST-NATAL MATERNITY ROUTINE IPV ASSESSMENT RATES (APRIL – JUNE 2019) (N=20)



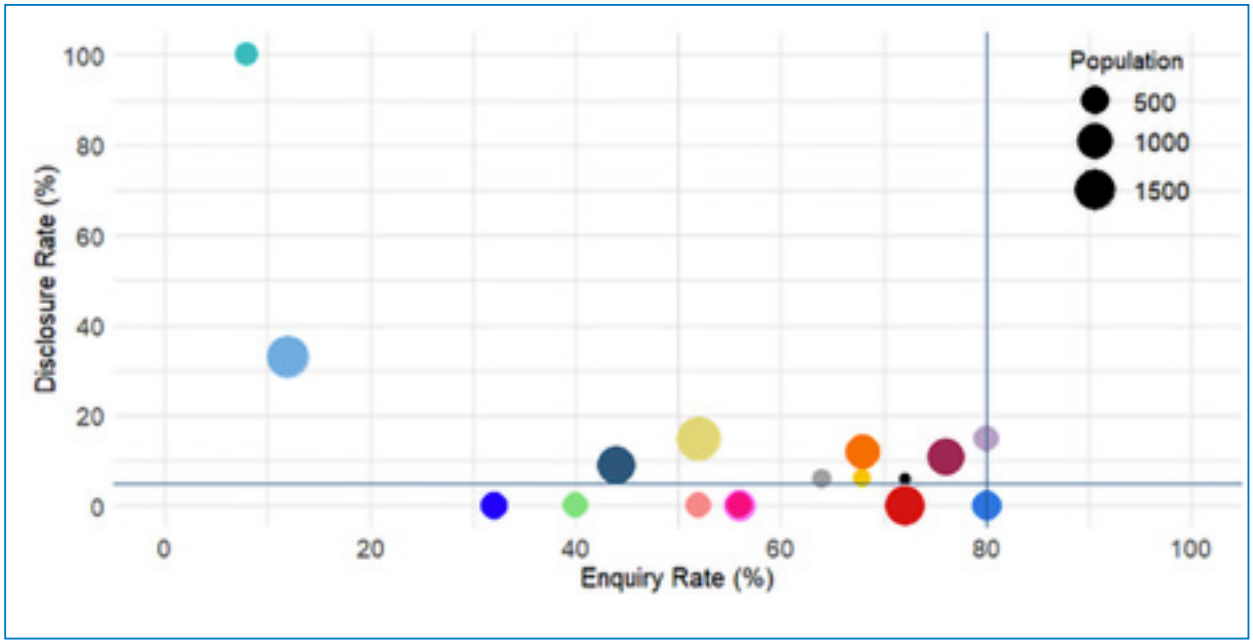
Among women who received an IPV routine enquiry, **disclosure rates** ranged from 0% to 100%. Eleven DHBs (Auckland, Capital & Coast, Counties Manukau, Hawke's Bay, South Canterbury, Taranaki, Waikato, Wairarapa, Waitemata, West Coast and Whanganui) met the disclosure target of ≥ 5% (Figure 15). Nine DHB snapshot samples captured zero IPV disclosures.

FIGURE 15: DHB POST-NATAL MATERNITY INTIMATE PARTNER VIOLENCE DISCLOSURE RATES (APRIL – JUNE 2019) (N=20)



The relationship between assessment and disclosure rates in graphed in Figure 16. One DHB (Taranaki) achieved the target of ≥ 80% IPV assessment rate with ≥ 5% disclosure rate (Figure 16). Capital & Coast and West Coast DHBs achieved high IPV routine assessment rates (76% and 72%) with disclosure rates of 11% and 6% respectively.

FIGURE 16: DHB POST-NATAL MATERNITY INTIMATE PARTNER VIOLENCE ROUTINE ASSESSMENT AND DISCLOSURE RATES (APRIL – JUNE) 2019 (N=20)



Note: Some points include more than one DHB. Bubble size refers to the total number of eligible patients admitted to the post-natal maternity department of each DHB.

National Estimates

Assessment. Among admissions by women to postnatal maternity services during the three month audit period (April–June):

- 53% (95% CI 48, 59) of women were assessed for IPV. This is the first decrease in IPV assessment in the post-natal service since 2014.
- Nationwide, we estimate an IPV assessment was conducted with 7,154 women during the 2019 audit period (Figure 17 and Appendix H).

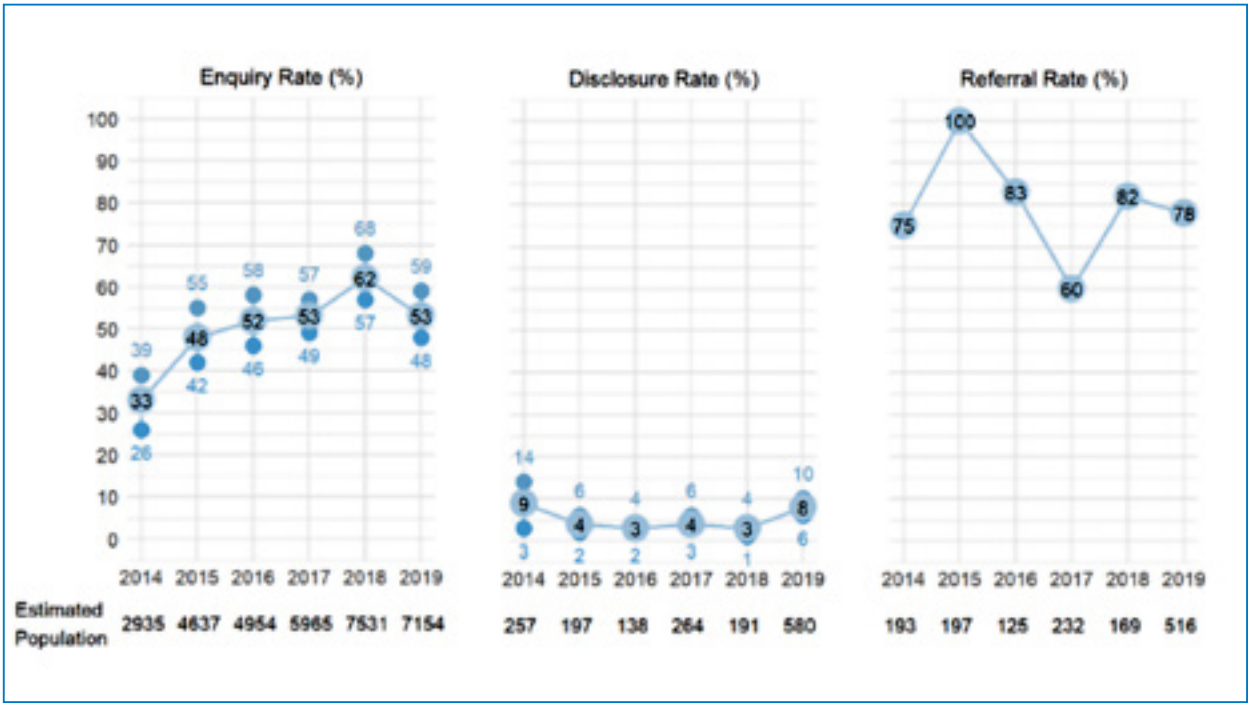
Disclosure. Among women admitted to post-natal maternity services during the three month audit period (April – June) who were assessed for IPV:

- The IPV identification rate was 8% (95% CI 6, 10). This is an increase from a stagnant position of 3-4% from 2015-2018.
- Nationwide, we estimate IPV was identified in 580 women during the audit period.

Specialist Referral/Consultation. Among women admitted to post-natal maternity services during the three month audit period (April–June) in which IPV was identified:

- 78% received a specialist referral consultation.
- Nationwide, we estimate 516 women were provided specialist IPV consultation or referral.
- The increase in disclosure rates meant the number of women given access to specialist services was the highest since 2014 (ranging from 125 women in 2016 to 232 women in 2017).

FIGURE 17: DHB POST-NATAL MATERNITY INTIMATE PARTNER VIOLENCE ROUTINE ASSESSMENT, DISCLOSURE AND REFERRAL RATES (2014-2019)



Note: Error bars represent 95% confidence intervals.

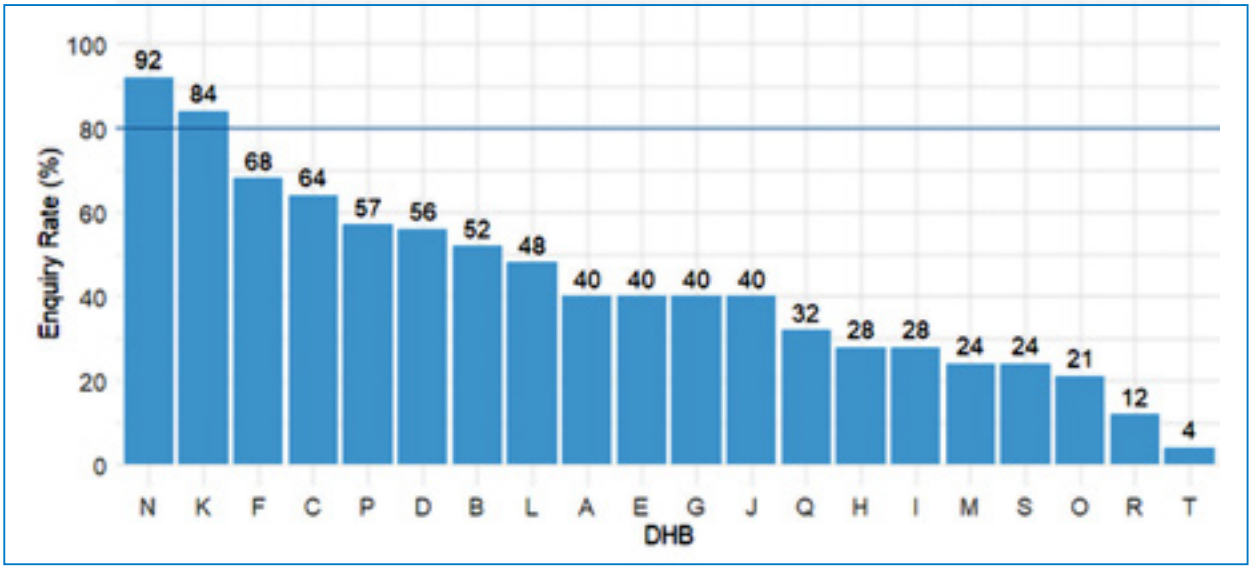
Child Health In-Patient

DHB results

Twenty DHBs provided data from 20 child health in-patient locations. They reported a total of 11,180 admissions by children during the three month audit period (April – June) Random sampling from the 20 locations resulted in 523 (one DHB submitted data from two hospital sites and two cases were missing), admissions audited for the 2019 snapshot.

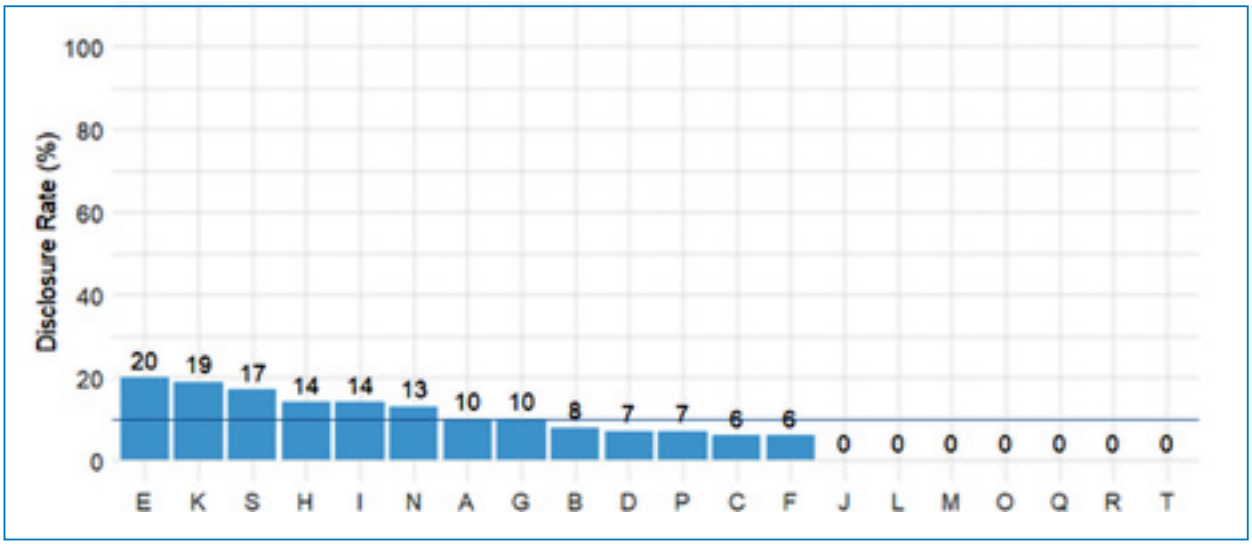
Across DHBs, child health in-patient routine **assessment rates** of female guardians or caregivers ranged from 4% to 92% (Figure 18). Two DHBs (Counties Manukau and Taranaki) achieved the target IPV routine assessment rate of ≥ 80%.

FIGURE 18: DHB CHILD HEALTH IN-PATIENT INTIMATE PARTNER VIOLENCE ASSESSMENT RATES (APRIL - JUNE 2019) (N=20)



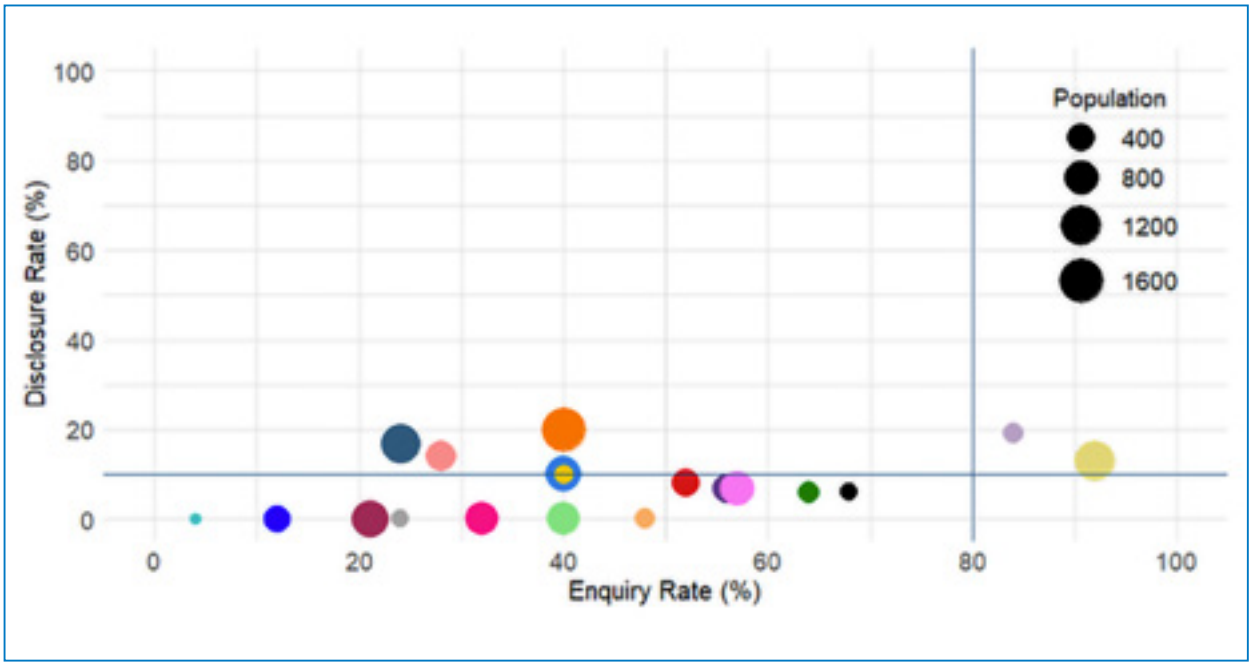
Among women who received an IPV routine enquiry, disclosure rates ranged from 0% to 20%. Eight DHBs (Auckland, Bay of Plenty, Counties Manukau, MidCentral, Taranaki, Waikato, Wairarapa and Waitemata) met the disclosure target of ≥ 10 (Figure 19). Seven DHB Snapshot samples captured zero IPV disclosures.

FIGURE 19: DHB CHILD HEALTH IN-PATIENT INTIMATE PARTNER VIOLENCE DISCLOSURE RATES (APRIL – JUNE 2019) (N=20)



The relationship between assessment and disclosure rates is graphed in Figure 20. Two DHBs (Counties Manukau and Taranaki) achieved the target of ≥ 80% IPV assessment rate with ≥ 10% disclosure rate.

FIGURE 20: DHB CHILD HEALTH IN-PATIENT INTIMATE PARTNER VIOLENCE ROUTINE ASSESSMENT AND DISCLOSURE RATES (APRIL – JUNE 2019) (N=20)



Note: Some points include more than one DHB. Bubble size refers to the total number of eligible patients admitted to the child health in-patient department of each DHB.

National Estimates

Assessment. Among female caregivers of any child aged 16 and under admitted to a general paediatric inpatient ward during the three month audit period (April–June):

- 44% (95% CI 38, 49) of women were assessed for IPV. Assessment rates have ranged from 35% (2015) to 44% (2019) over the five snapshot audits.
- Nationwide, we estimate an IPV assessment was conducted with 4,864 women during the 2019 audit period (Figure 21 and Appendix H).

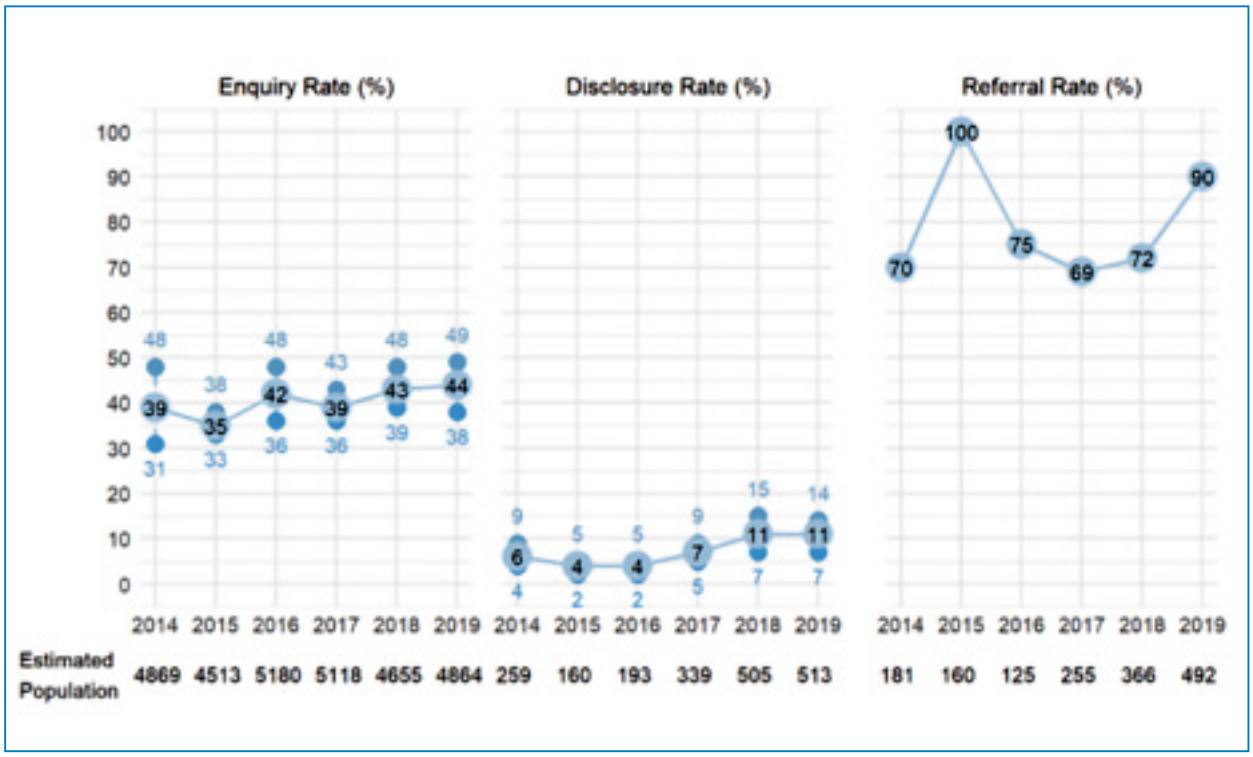
Disclosure. Among female caregivers of any child aged 16 and under admitted to a general paediatric inpatient ward during the three month audit period who were assessed for IPV:

- The IPV identification rate was 11% (95% CI 7, 14), unchanged from 2018.
- Nationwide, we estimate IPV was identified in 513 women during the audit period.

Specialist Referral/Consultation. Among female caregivers of any child aged 16 and under admitted to a general paediatric inpatient ward during the three month audit period in which IPV was identified:

- 90% received a specialist referral consultation, an increase of 18% since 2018.
- Nationwide, we estimate 492 women were provided specialist IPV consultation or referral, the highest across the five snapshot audits (2014–2019).

FIGURE 21: DHB CHILD HEALTH IN-PATIENT INTIMATE PARTNER VIOLENCE ROUTINE ASSESSMENT, DISCLOSURE AND REFERRAL RATES (2014–2019)



Note: Error bars represent 95% confidence intervals.

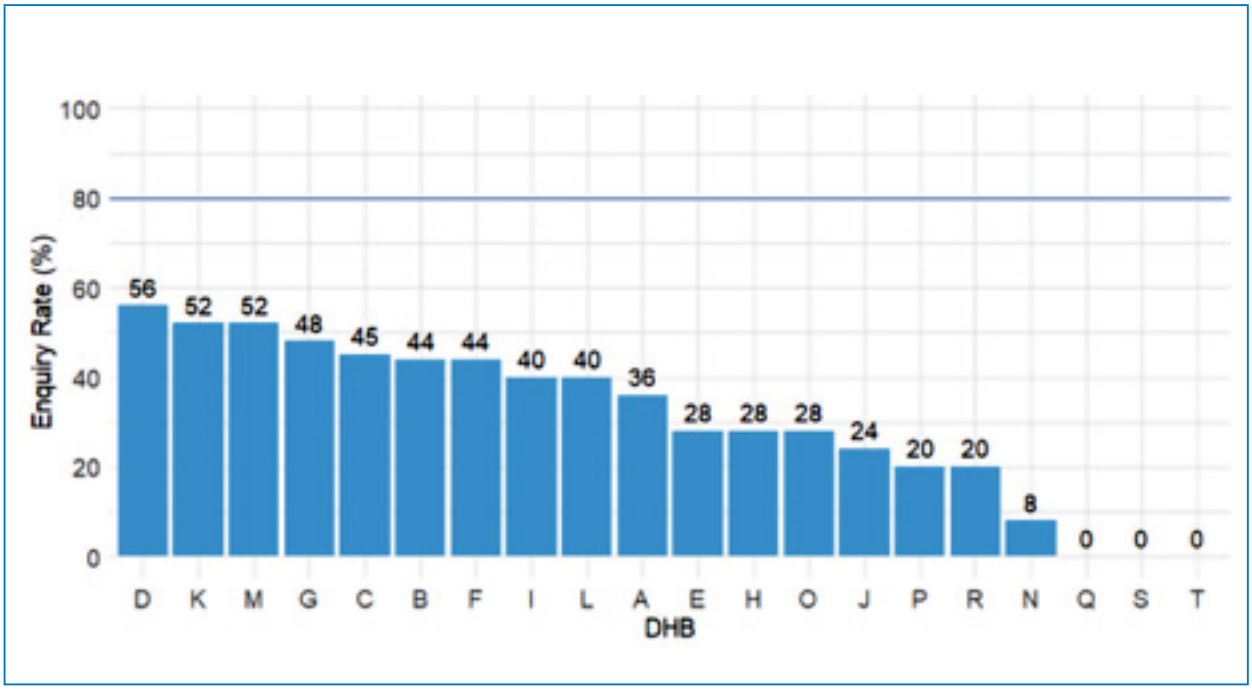
Emergency Department

DHB Results

Twenty DHBs provided data from 20 emergency departments. They reported that 118,513 women presented to the emergency departments during the three month audit period (April – June 2019). Random sampling from the 20 locations resulted in 529 cases (one DHB submitted data from two hospital sites, one DHB sampled 29 cases) audited for the 2019 snapshot.

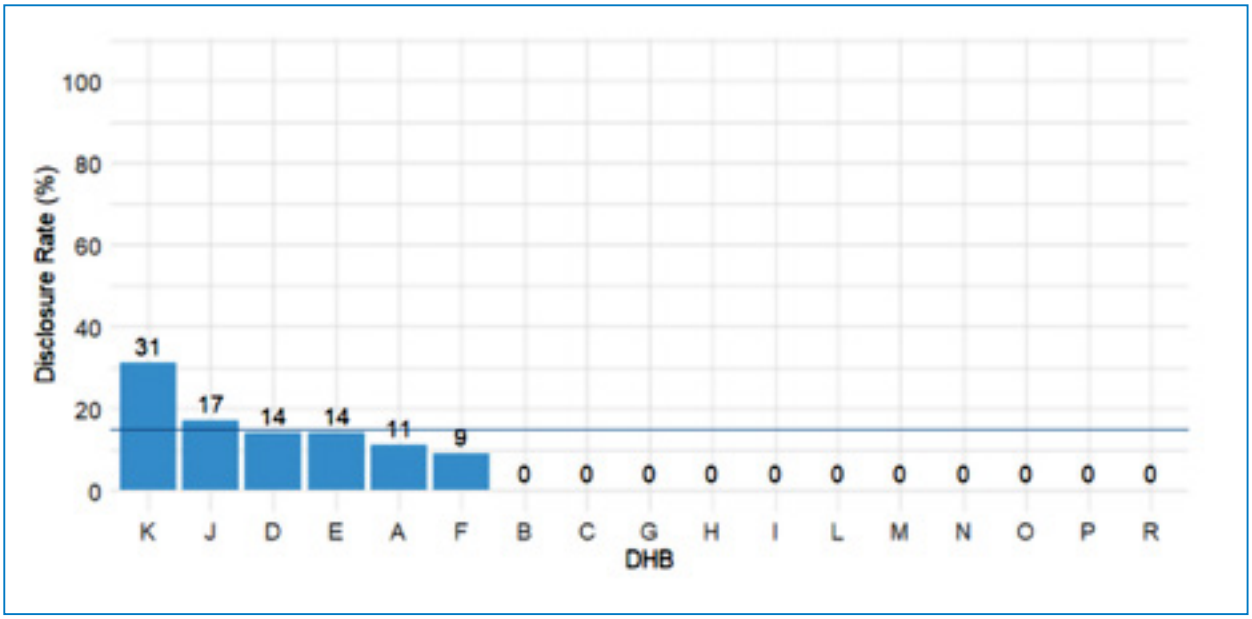
Across DHBs, emergency department routine **assessment rates** of women aged 16 years and over ranged from 0% to 56% (Figure 22). No DHBs achieved the target IPV routine assessment rate of ≥ 80%. Three DHB snapshot samples captured zero IPV assessments.

FIGURE 22: DHB EMERGENCY DEPARTMENT INTIMATE PARTNER VIOLENCE ROUTINE ASSESSMENT RATES (APRIL – JUNE) 2019 (N=20)



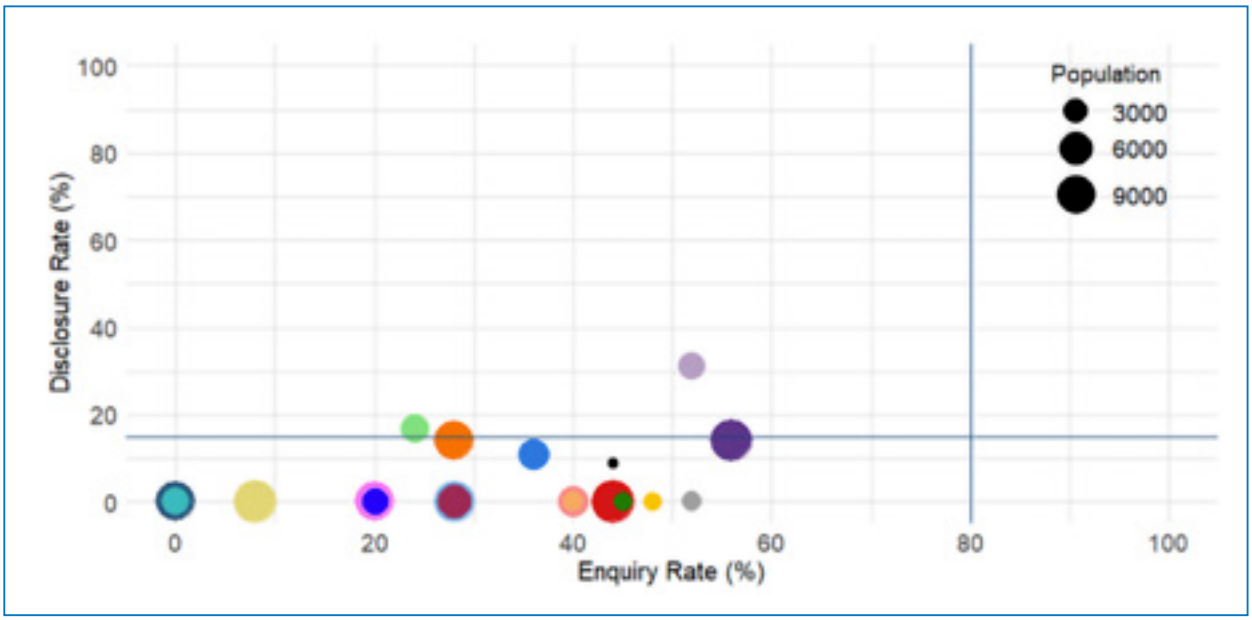
Among women who received an IPV routine enquiry, **disclosure rates** ranged from 0% to 31%. Two DHBs (Northland and Taranaki) met the disclosure target of ≥ 15% (Figure 23). Fourteen DHB Snapshot samples captured zero IPV disclosures.

FIGURE 23: DHB EMERGENCY DEPARTMENT INTIMATE PARTNER VIOLENCE DISCLOSURE RATES (APRIL – JUNE) 2019 (N=17; THREE DHBS RECORDED A ZERO SCREENING RATE)



The relationship between assessment and disclosure rates in graphed in Figure 24. No DHBs achieved the target of ≥ 80% IPV assessment rate with ≥ 15% disclosure rate.

FIGURE 24: DHB EMERGENCY DEPARTMENT INTIMATE PARTNER VIOLENCE ROUTINE ASSESSMENT AND DISCLOSURE RATES (APRIL – JUNE) 2019 (N=20)



Note: Some points include more than one DHB. Bubble size refers to the total number of eligible patients admitted to the emergency department of each DHB.

National Estimates

Assessment. Among women who presented to the emergency department during the three month audit period (April–June):

- 28% (95% CI 24, 31) of women were assessed for IPV. Assessment rates have ranged between 23% (2015) and 32% (2018) across the four snapshot audits.
- Nationwide, we estimate an IPV assessment was conducted with 32,899 women during the 2019 audit period (Figure 25 and Appendix H).

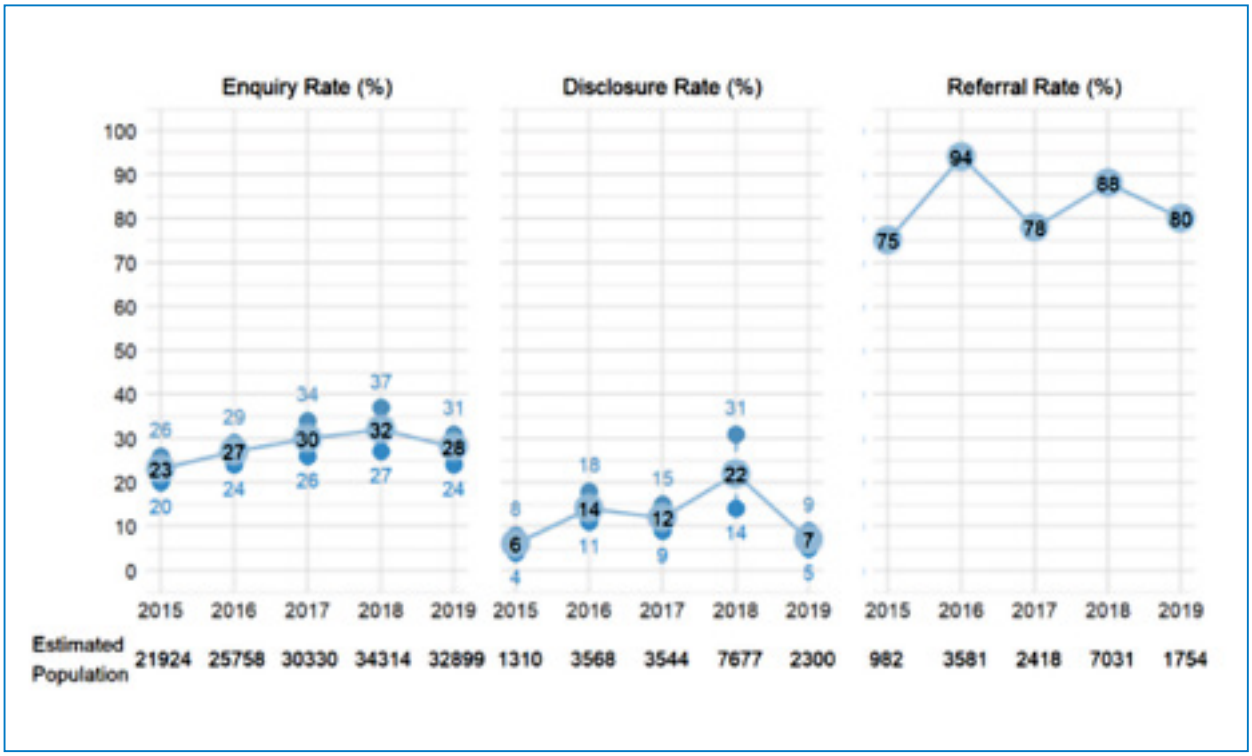
Disclosure. Among women who presented to the emergency department during the three month audit period (April – June) who were assessed for IPV:

- The IPV identification rate was 7% (95% CI 5, 9). This is a 15% decrease from 2018, the second lowest recorded rate over the four snapshot audits (2015–2019).
- Nationwide, we estimate IPV was identified in 2,300 women during the audit period, compared to 7,677 women in 2018.

Specialist Referral/Consultation. Among women who presented to the emergency department during the three month audit period (April–June) in which IPV was identified:

- 80% received a specialist referral consultation.
- Nationwide, we estimate 1,754 women were provided specialist IPV consultation or referral.
- The low disclosure rates mean the estimated number of women given access to specialist services decreased by 5,277 since 2018.

FIGURE 25: DHB EMERGENCY DEPARTMENT INTIMATE PARTNER VIOLENCE ROUTINE ASSESSMENT, DISCLOSURE AND REFERRAL RATES (2015–2019)



Note: Error bars represent 95% confidence intervals.

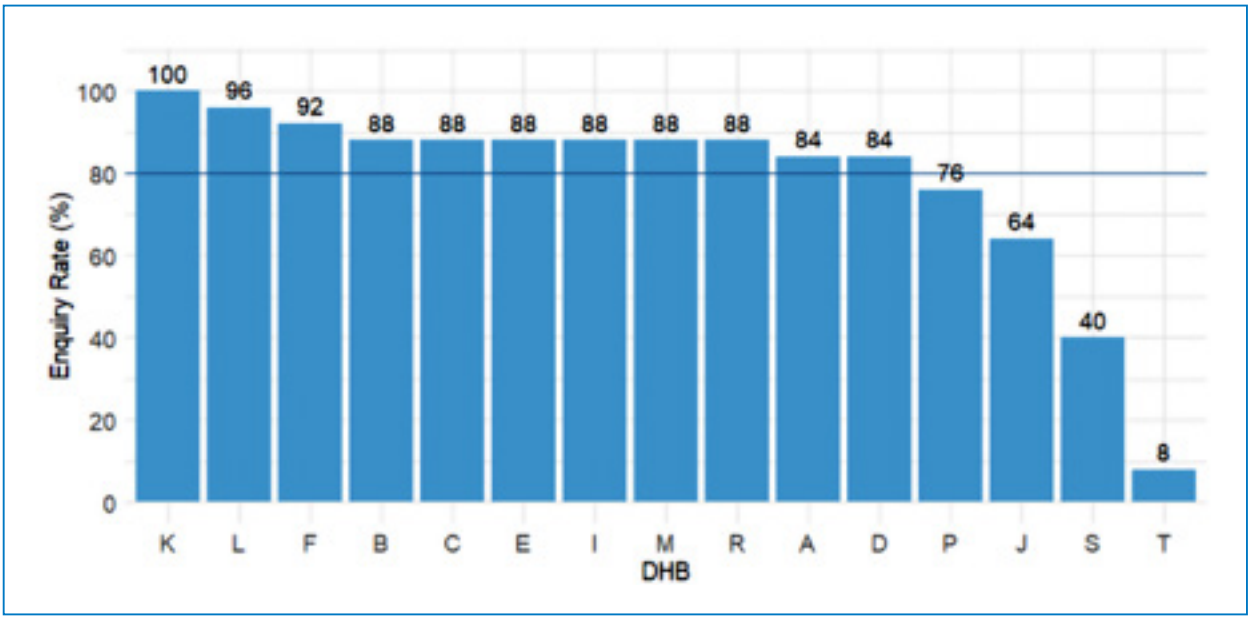
Sexual Health Services

DHB Results

Nationally, 15 DHBs submitted Snapshot data in 2019 (5 DHBs contract the service to an NGO). They reported that 6,039 women presented to the sexual health service during the three month audit period (April – June). Random sampling from the 15 locations resulted in 375 cases audited for the 2019 snapshot.

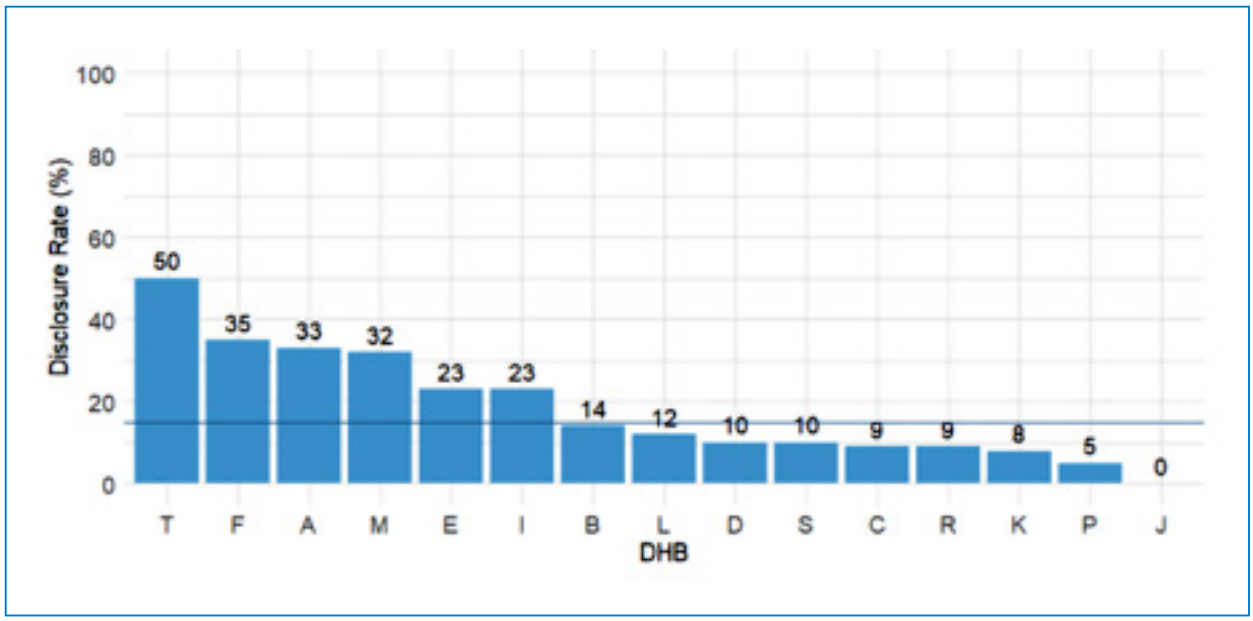
Across DHBs, sexual health service routine **assessment rates** of women aged 16 years and over ranged from 8% to 100% (Figure 26). Eleven DHBs (Bay of Plenty, Canterbury, Lakes, Midcentral, Nelson Marlborough, South Canterbury, Tairawhiti, Taranaki, Waikato, West Coast and Whanganui) achieved the target IPV routine assessment rate of ≥ 80%.

FIGURE 26: DHB SEXUAL HEALTH SERVICE INTIMATE PARTNER VIOLENCE ROUTINE ASSESSMENT RATES (APRIL – JUNE) 2019 (N=15 DHBS)



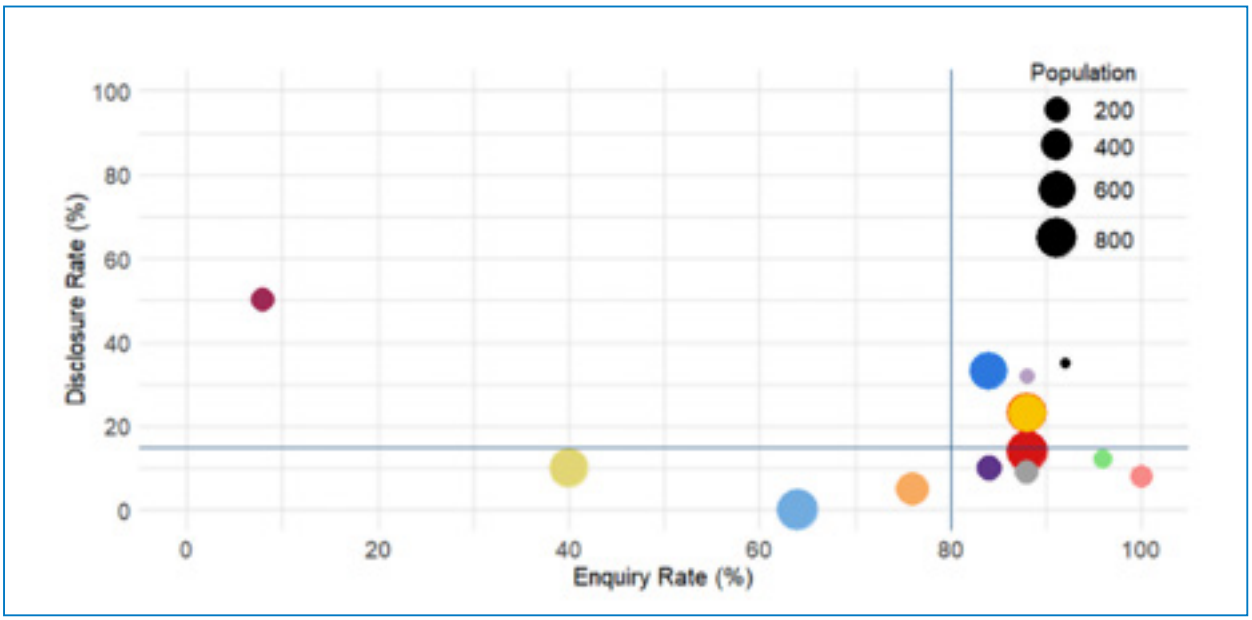
Among women who received an IPV routine enquiry, disclosure rates ranged from 0% to 50%. Six DHBs (Bay of Plenty, Hawkes Bay, Midcentral, South Canterbury, Waikato, West Coast) met the disclosure target of ≥ 15% (Figure 27). One DHB Snapshot sample captured zero IPV disclosures.

FIGURE 27: DHB SEXUAL HEALTH SERVICE INTIMATE PARTNER VIOLENCE DISCLOSURE RATES (APRIL – JUNE) 2019 (N=15)



The relationship between assessment and disclosure rates in graphed in Figure 28. Five DHBs (Bay of Plenty, Midcentral, South Canterbury, Waikato, West Coast) achieved the target of ≥ 80% IPV assessment rate with ≥ 15% disclosure rate.

FIGURE 28: DHB SEXUAL HEALTH SERVICE INTIMATE PARTNER VIOLENCE ROUTINE ASSESSMENT AND DISCLOSURE RATES (APRIL – JUNE) 2019 (N=15 DHBS)



Note: Some points include more than one DHB. Bubble size refers to the total number of eligible patients admitted to the sexual health service of each DHB.

National Estimates

Assessment. Among women who presented to sexual health services during the three month audit period (April–June):

- 75% (95% CI 68, 82) of women were assessed for IPV. Assessment rates have steadily increased over the four Snapshot audits (2015–2019).
- Nationwide, we estimate an IPV assessment was conducted with 4,543 women during the 2019 audit period (Figure 29 and Appendix H).

Disclosure. Among women who presented to sexual health services during the three month audit period (April – June) who were assessed for IPV:

- The IPV identification rate was 16% (95% CI 12, 19). Disclosure rates have ranged between 10% (2018) and 20% (2015) across the four snapshot audits.
- Nationwide, we estimate IPV was identified in 713 women during the audit period.

Specialist Referral/Consultation. Among women who presented to sexual health services during the three month audit period (April–June) in which IPV was identified:

- 63% received a specialist referral consultation.
- Nationwide, we estimate 437 women were provided specialist IPV consultation or referral.

FIGURE 29: DHB SEXUAL HEALTH SERVICE INTIMATE PARTNER VIOLENCE ROUTINE ASSESSMENT AND DISCLOSURE RATES (2015–2019)

Note: Error bars represent 95% confidence intervals.

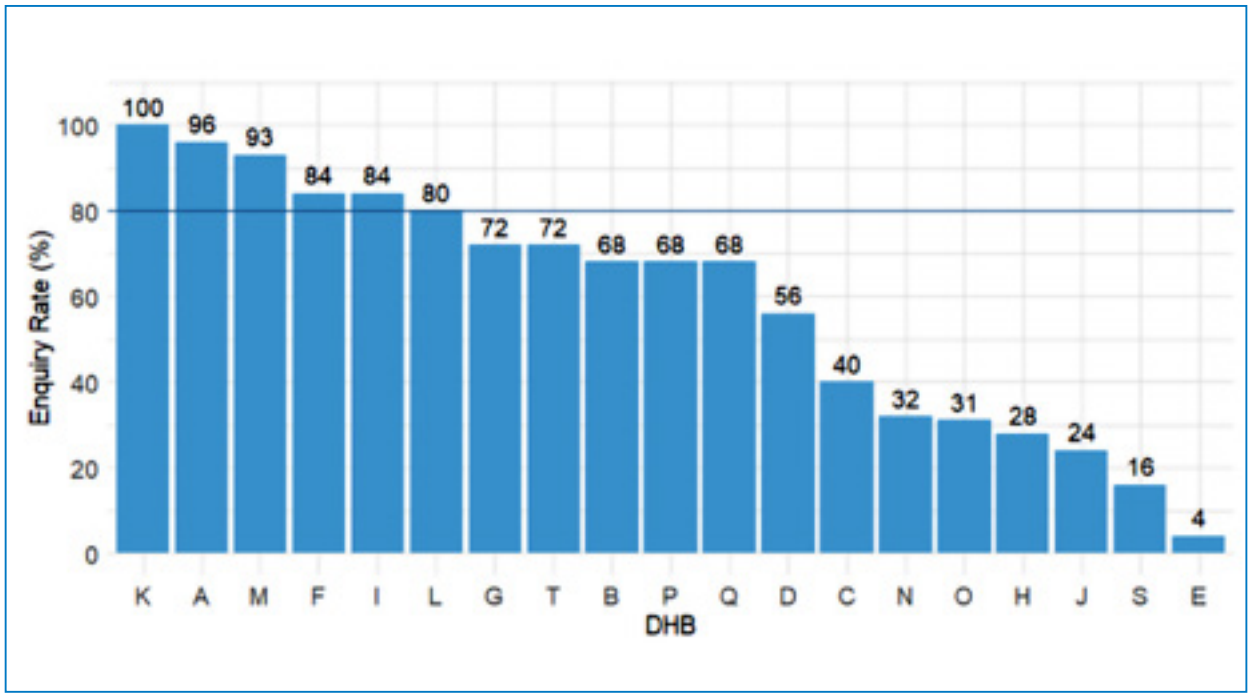
Community Mental Health Services

DHB Results

Nationally, 19 DHBs (95%) provided snapshot audit data from 19 adult community mental health services in 2019. They reported that 6,473 new women clients (seen for the first time by the service) and previous women clients (discharged and re-referred to the service as if they were a new client) aged 16 years and over presented to adult community mental health services during the three month audit (April – June). Random sampling from the 19 locations resulted in 490 cases (one DHB with a small eligible population sampled 14 records; one DHB sampled two sites; and another DHB sampled 26 records) audited for the 2019 snapshot. One DHB did not submit data.

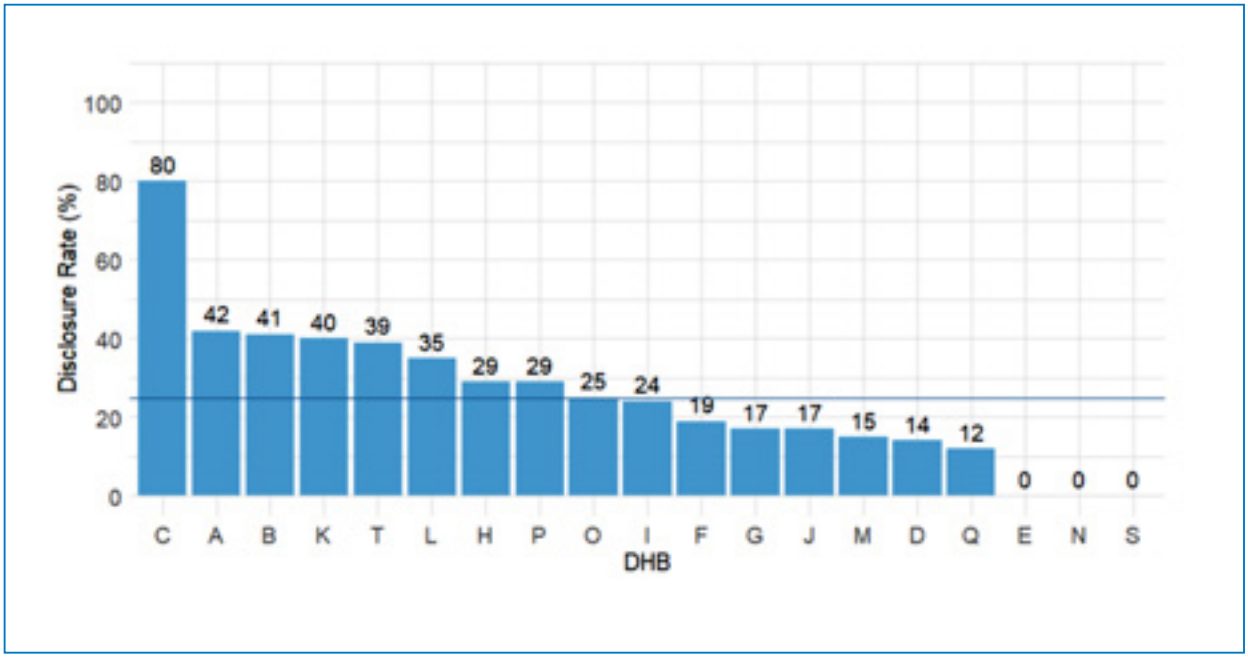
Across DHBs, adult community mental health routine **assessment rates** of women aged 16 years and over ranged from 4% to 100% (Figure 30). Six DHBs (Bay of Plenty, Midcentral, Nelson Marlborough, South Canterbury, Taranaki and West Coast) achieved the target IPV routine assessment rate of ≥ 80%.

FIGURE 30: DHB COMMUNITY MENTAL HEALTH SERVICE INTIMATE PARTNER VIOLENCE ROUTINE ASSESSMENT RATES (APRIL – JUNE) 2019 (N=19)



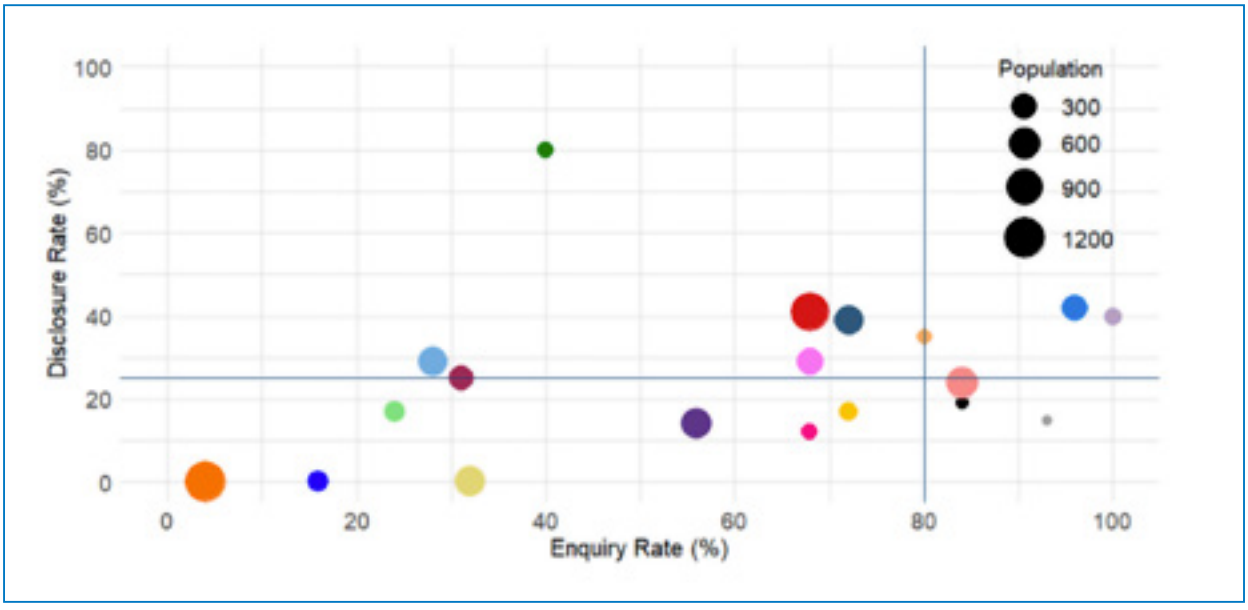
Among women who received an IPV routine enquiry, **disclosure rates** ranged from 0% to 80%. Nine DHBs (Bay of Plenty, Canterbury, Capital & Coast, Hawkes Bay, Nelson Marlborough, Southern, Tairawhiti, Taranaki and Waitemata) met the disclosure target of ≥ 25% (Figure 31). Three DHB Snapshot samples captured zero IPV disclosures.

FIGURE 31: DHB COMMUNITY MENTAL HEALTH SERVICE INTIMATE PARTNER VIOLENCE DISCLOSURE RATES (APRIL – JUNE) 2019 (N=19)



The relationship between assessment and disclosure rates in graphed in Figure 32. Three DHBs (Bay of Plenty, Nelson Marlborough and Taranaki) achieved the target of ≥ 80% IPV assessment rate with ≥ 25% disclosure rate.

FIGURE 32: DHB COMMUNITY MENTAL HEALTH SERVICE INTIMATE PARTNER VIOLENCE ROUTINE ASSESSMENT AND DISCLOSURE RATES (APRIL – JUNE) 2019 (N=19)



Note: Bubble size refers to the total number of eligible patients admitted to the community mental health service of each DHB. Some points include more than one DHB.

National Estimates

Assessment. Among women who presented to community mental health services during the three month audit period (April–June):

- 49% (95% CI 42, 56) of women were assessed for IPV.
- Nationwide, we estimate an IPV assessment was conducted with 3,172 women during the 2019 audit period. Figure 33 and Appendix H.

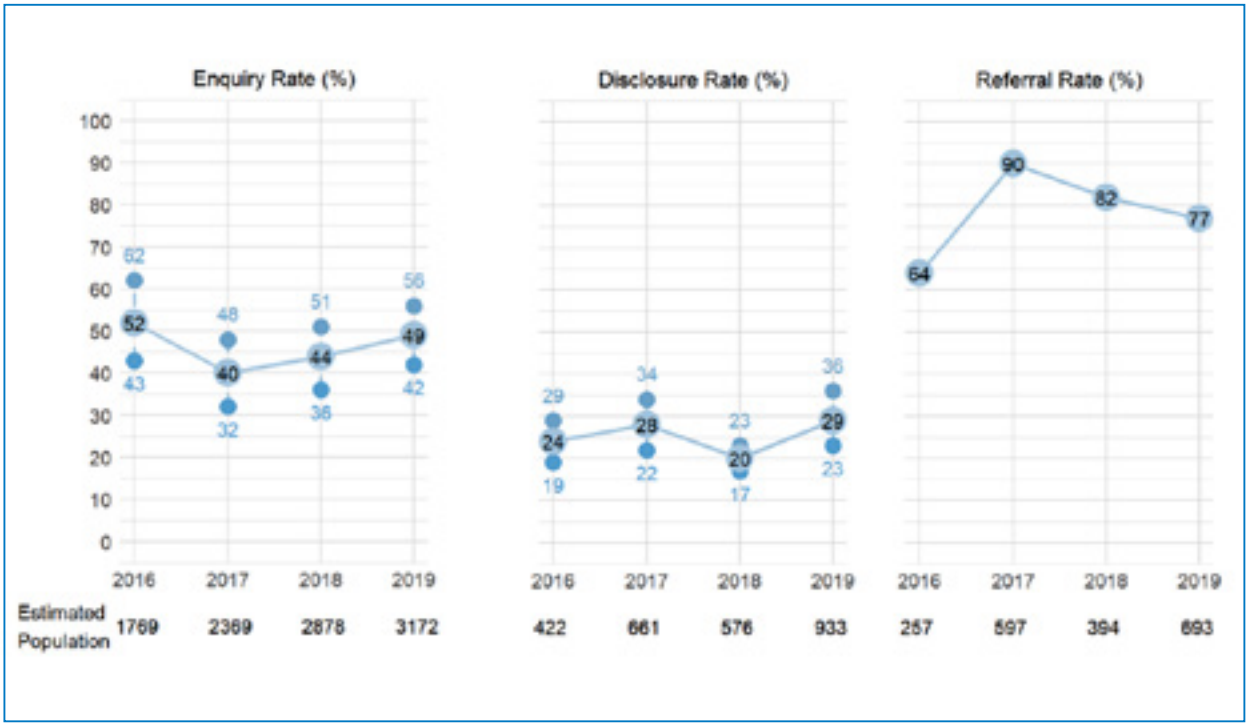
Disclosure. Among women who presented to community mental health services during the three month audit period (April – June) who were assessed for IPV:

- The IPV identification rate was 29% (95% CI 23, 36).
- Nationwide, we estimate IPV was identified in 933 women during the audit period.

Specialist Referral/Consultation. Among women who presented to community mental health services during the three month audit period (April–June) in which IPV was identified:

- 77% received a specialist referral consultation.
- Nationwide, we estimate 693 women were provided specialist IPV consultation or referral.
- Increased assessment and disclosure rates in 2019 mean an estimated further 299 women were given access to specialist services, the highest referral rate for the service across the four snapshot audits (2015–2019).

FIGURE 33: DHB COMMUNITY MENTAL HEALTH SERVICE INTIMATE PARTNER VIOLENCE ROUTINE ASSESSMENT, DISCLOSURE AND REFERRAL RATES (2016 – 2019)



Note: Error bars represent 95% confidence intervals.

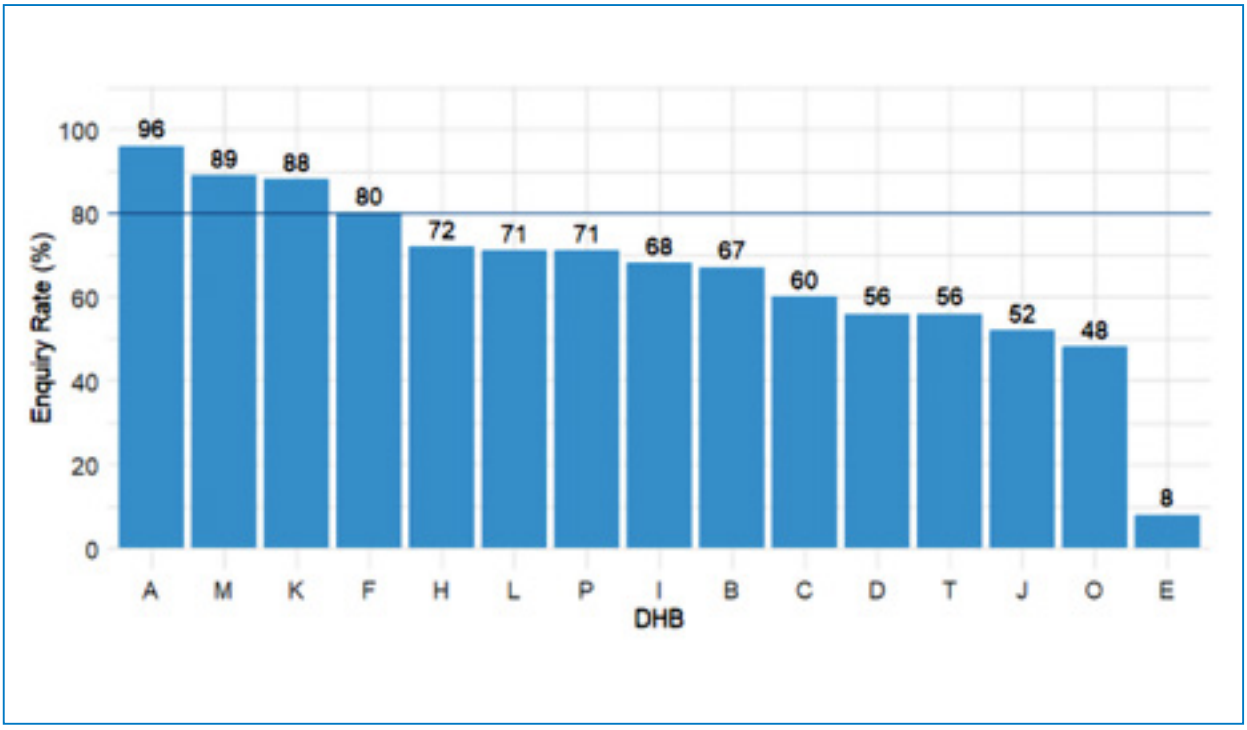
Community Alcohol and Drug Services

DHB Results

Nationally, 15 DHBs provided snapshot audit data in 2019. Four DHBs contract the service to an NGO and one DHB has amalgamated the service with another service. DHBs reported 1,780 new women clients (seen for the first time who had completed at least one face to face contact) and previous women clients (discharged and re-referred to service presented to community alcohol and drug services during the three month audit period (April – June). Random sampling from the 15 locations resulted in 346 cases audited for the 2019 snapshot. Several DHBs submitted fewer records due to small eligible population sizes.

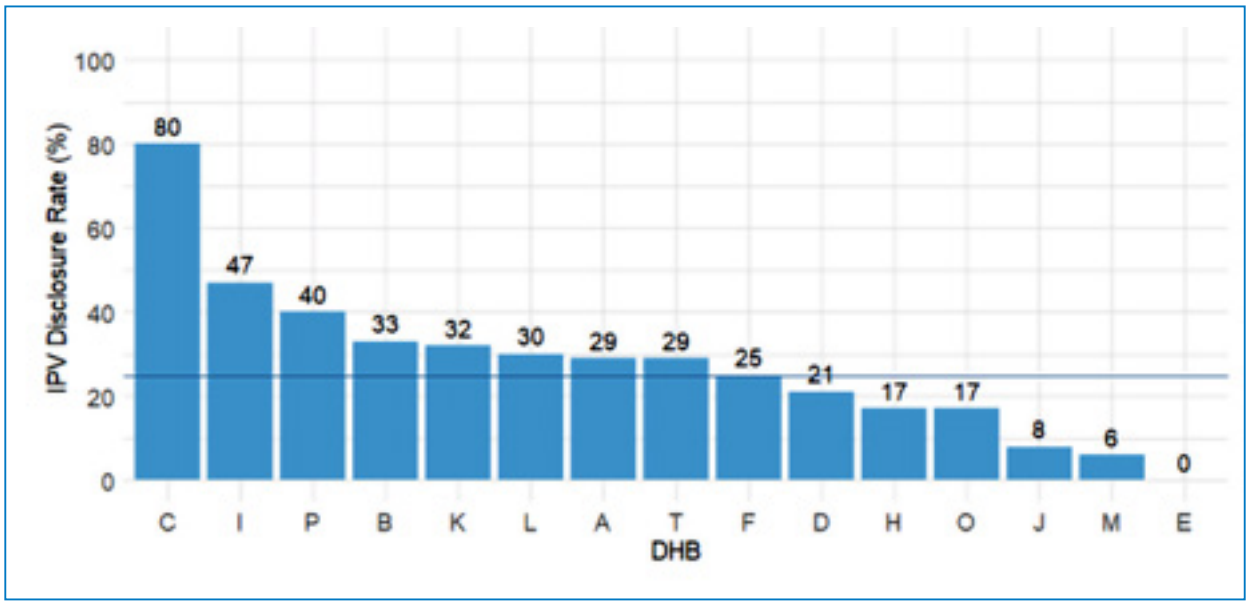
Across DHBs, community alcohol and drug routine **assessment rates** of women aged 16 years and over ranged from 8% to 96% (Figure 34). Four DHBs (Bay of Plenty, South Canterbury, Taranaki and West Coast) achieved the target IPV routine assessment rate of ≥ 80%.

FIGURE 34: DHB COMMUNITY ALCOHOL AND DRUG SERVICES INTIMATE PARTNER VIOLENCE ROUTINE ASSESSMENT RATES (APRIL – JUNE) 2019 (N=15)



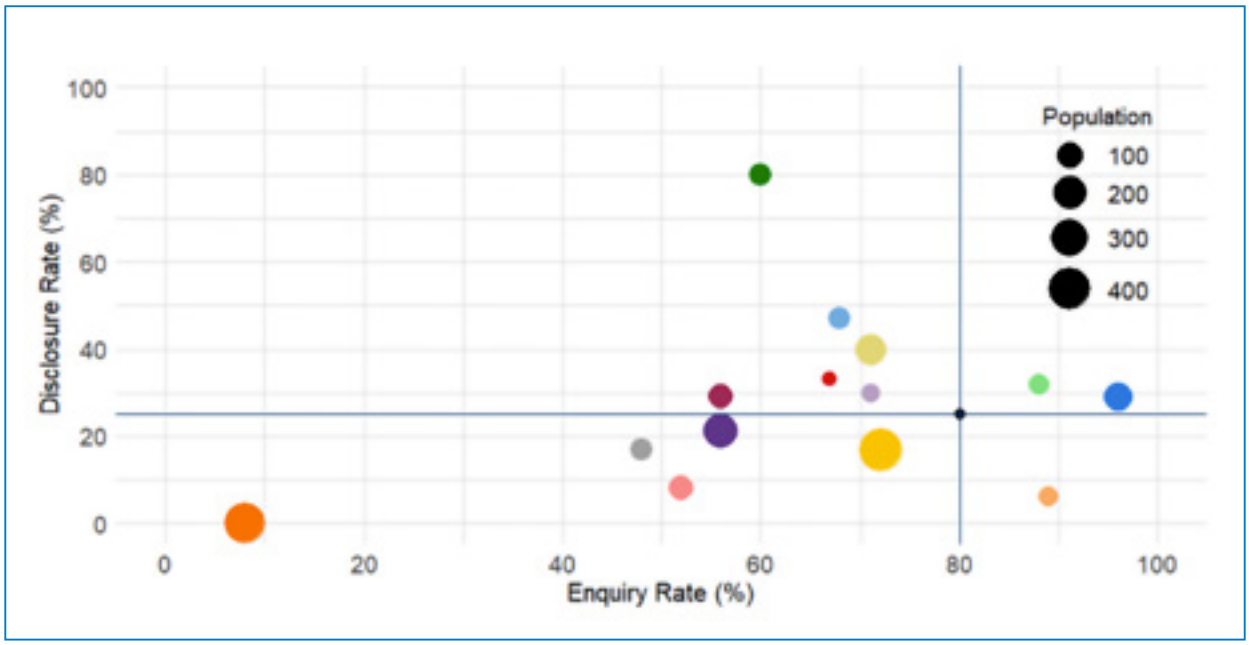
Among women who received an IPV routine enquiry, **disclosure rates** ranged from 0% to 80%. Nine DHBs (Bay of Plenty, Canterbury, Hawke's Bay, Midcentral, Nelson Marlborough, Southern, Tairawhiti, Taranaki, and West Coast) met the disclosure target of ≥ 25% (Figure 35). One DHB Snapshot sample captured zero IPV disclosures.

FIGURE 35: DHB COMMUNITY ALCOHOL AND DRUG SERVICES INTIMATE PARTNER VIOLENCE DISCLOSURE RATES (APRIL – JUNE) 2019 (N=15)



The relationship between assessment and disclosure rates in graphed in Figure 36. Three DHBs (Bay of Plenty, Taranaki and West Coast) achieved the target of ≥ 80% IPV assessment rate with ≥ 25% disclosure rate.

FIGURE 36: DHB COMMUNITY ALCOHOL AND DRUG SERVICE INTIMATE PARTNER VIOLENCE ROUTINE ASSESSMENT AND DISCLOSURE RATES (APRIL – JUNE) 2019 (N=15)



Note: Bubble size refers to the total number of eligible patients admitted to the community alcohol and drug service of each DHB.

National Estimates

Assessment. Among women who presented to community alcohol and drug services during the three month audit period (April–June):

- 56% (95% CI 43, 69) of women were assessed for IPV.
- Nationwide, we estimate an IPV assessment was conducted with 993 women during the 2019 audit period. Figure 37 and Appendix H.

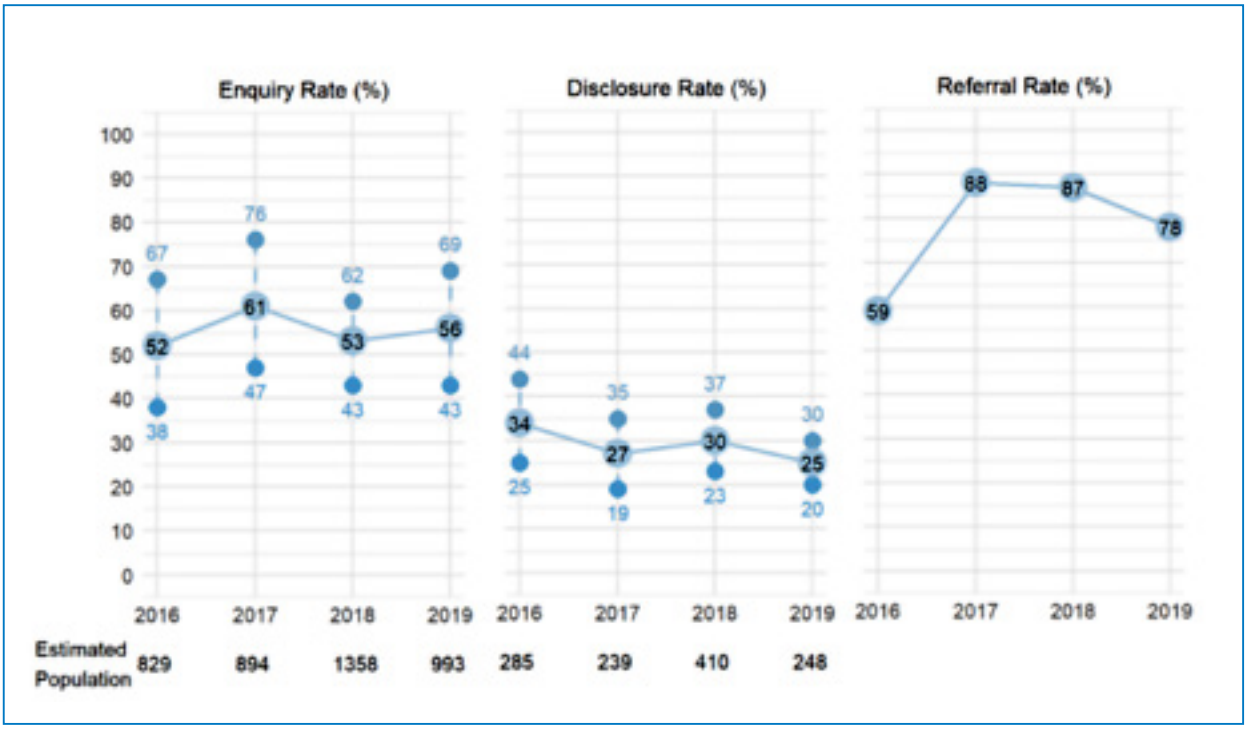
Disclosure. Among women who presented to community alcohol and drug services during the three month audit period (April – June) who were assessed for IPV:

- The IPV identification rate was 25% (95% CI 20, 30).
- Nationwide, we estimate IPV was identified in 248 women during the audit period.

Specialist Referral/Consultation. Among women who presented to community alcohol and drug services during the three month audit period (April–June) in which IPV was identified:

- 78% received a specialist referral consultation.
- Nationwide, we estimate 210 women were provided specialist IPV consultation or referral.

FIGURE 37: DHB COMMUNITY ALCOHOL AND DRUG SERVICES INTIMATE PARTNER VIOLENCE ROUTINE ASSESSMENT, DISCLOSURE AND REFERRAL RATES (2016–2019)



Note: Error bars represent 95% confidence intervals.

FINDINGS
ETHNICITY

In this section we interrogate the system infrastructure and clinical snapshot audit data regarding ethnicity. Tangata whenua continue to suffer the effects of colonisation with significant persisting health inequities.[42-43] As a social determinant of health, violence within whānau has reached epidemic proportions for Māori.[44] Reducing health outcome disparities for Māori is a key government policy objective, however, issues persist in the collation and interpretation of Māori-specific data, such as the context in which self-identification takes place.[41,45] The VIP evaluation systematically collects and reports on system infrastructure (Delphi audits) and service delivery (snapshot clinical audits) for Māori, however caution must be exercised in interpreting the following findings. Critical analysis is necessary in understanding sites of racism embedded within health system responses to violence within whānau and the multiple stories behind the data.[45-46]

System Infrastructure

The 2019 median *Cultural Responsiveness* domain score was 74, an increase from 66 in 2018. However, large variation exists across DHBs with *Cultural Responsiveness* domain scores ranging from 30 to 100. The majority of DHBs have achieved indicators that involve addressing cultural responsiveness within policies. For example, 95% of DHBs report that cultural competency is evident within their VIP policy and training (*Cultural Responsiveness* indicators 2.1 and 2.2). Achievement of other indicators, however, suggests critical work is needed to support development of collaborative and reciprocal partnerships with Māori to inform VIP practice and policy.

For example, in the:

CULTURAL RESPONSIVENESS DOMAIN:

8 DHBs (40%)
seek feedback on VIP cultural responsiveness from Māori consumers (2.4)

4 DHBs (20%)
evaluate VIP service delivery for Māori by Māori in a way that is culturally appropriate and safe (5)

QUALITY IMPROVEMENT DOMAIN:

10 DHBs (50%)
report DHB leadership use a Māori quality framework to evaluate services for Māori (8)

9 DHBs (45%)
incorporate a Māori Health Unit review to improve VIP effectiveness for Māori. (8.1)

RESOURCE FUNDING DOMAIN:

11 (55%) DHBs
provide extra funding and resources to reduce the impact of family violence on Māori (1.1)

Snapshot clinical audits

VIP snapshot audits record up to three ethnicities per patient, consistent with MOH standards.[41] Due to ongoing data quality issues in collection and interpretation of ethnicity, data are prioritised for Māori (Māori and non-Māori). The reader should note small VIP snapshot audit sample sizes and diverse DHB populations make discriminating between DHBs difficult. Overall, 2019 VIP snapshot findings show both Māori and non-Māori are under-served, with high variation in the quality and consistency of both IPV and CAN assessment and disclosure rates across target services and DHBs (see figures below and Appendix I).

For example, during the 2019 snapshot audit period:

FOR CHILDREN UNDER TWO YEARS OF AGE PRESENTING TO THE EMERGENCY DEPARTMENT:

Of 175 visits by tamariki:

75 were assessed for CAN

9 concerns were noted

7 received specialist consultation

Of 366 visits by non-Maori children:

183 were assessed for CAN

11 concerns were noted

11 recieved specialist consultation

FOR WOMEN AGED 16 YEARS AND OVER PRESENTING TO AN EMERGENCY DEPARTMENT:

Of 112 visits by wāhine:

34 were assessed for IPV

2 disclosures were made

2 received specialist consultation

Of 423 visits by non-Māori women:

126 were assessed for IPV

8 disclosures were made

8 recieved specialist consultation

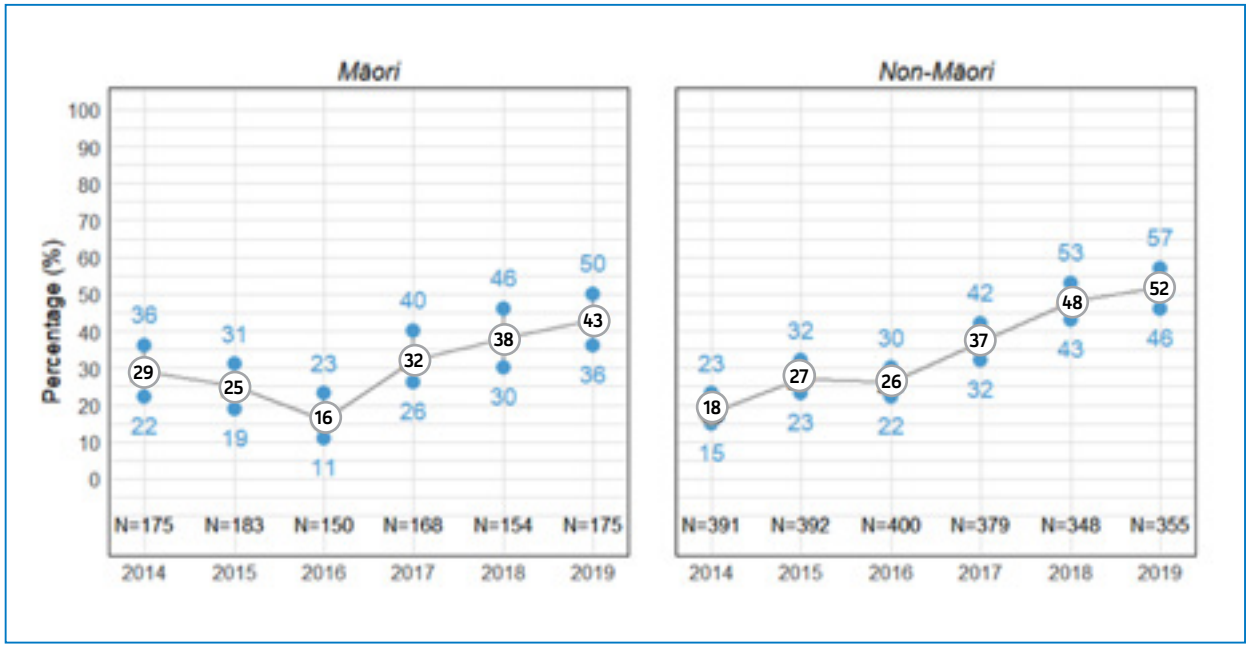
Findings suggest a lack of disparity between groups, with wide and overlapping confidence intervals (Figures 38 – 51).[47] However, this is not consistent with what we know about the systemic inequities Māori face when engaging with services. The low and variable assessment and disclosure rates prevent an adequate understanding of how culturally responsive VIP is for Māori. For example, Māori children have a far greater likelihood of being reported to child protection services[48–49] and Māori women are more likely to disclose violence as they have exhausted all other options for keeping themselves and their tamariki safe.[50,51]

Low CAN assessment coupled with high rates of concern indicate tamariki are currently targeted for child protection concerns. Completing the child protection checklist involves more than following the procedural steps. Identifying child protection concerns requires engaging advanced assessment skills that recognise the complex interplay between individual patient needs and the clinical context and inform when and how to respond to family or whānau needs.[52] Few DHBs consistently assess for child protection concerns. Only five DHBs met the assessment target for assessing four of every five children under the age of two presenting in an emergency department.

Low IPV disclosure rates suggest Māori wāhine do not feel safe in asking for help within VIP services and only do so when all other options are exhausted, compounding their entrapment (Figures 38 – 51).[50–51] The greatest differences in IPV assessment rates between Māori and non-Māori in 2019 were evident in *Child Health In-Patient* services with Māori over assessed (absolute difference of 7%) and in *Alcohol and Drug* services where Māori were under assessed (absolute difference of 8%). Again, confidence intervals were wide and overlapping (Figure 42, Figure 43, Figure 48, Figure 49).

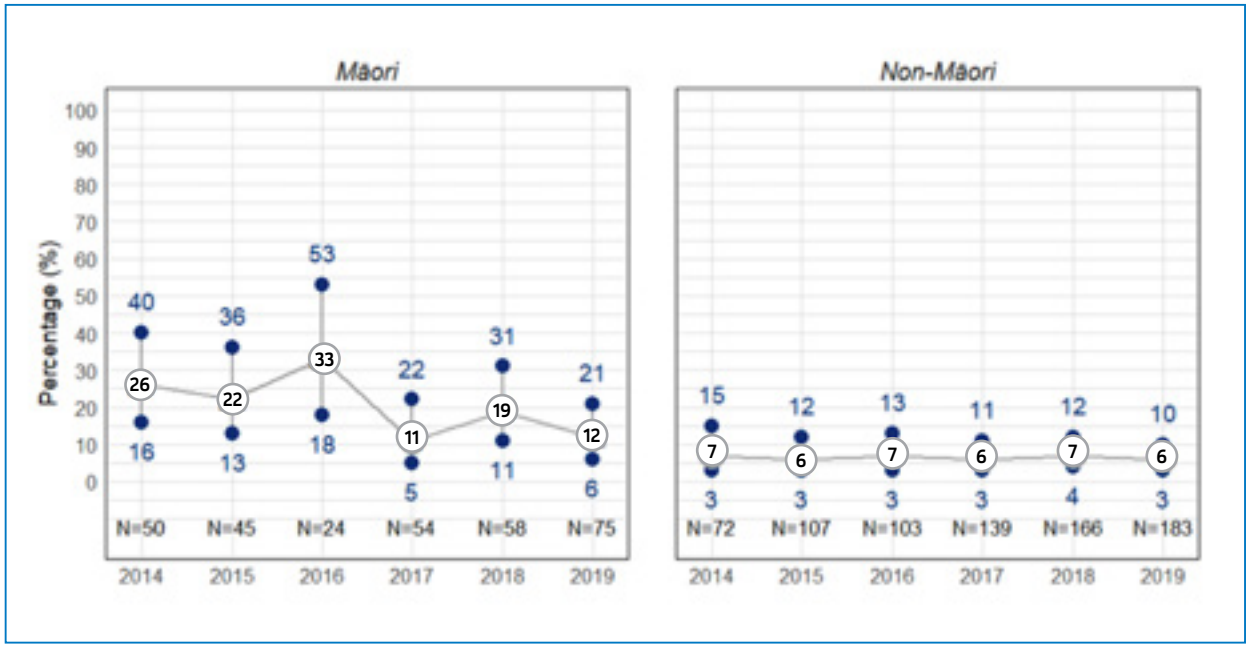
Compassionate, empathetic and restorative intervention is critical in engaging with Māori whānau.[49–50] Urgent work is needed to understand the experience of VIP intervention and the contexts in which it is received within to develop services responsive to the realities of living with violence as Māori.

FIGURE 38: CHILD ABUSE AND NEGLECT **ASSESSMENT** RATES FOR CHILDREN EVALUATED IN THE EMERGENCY DEPARTMENT BY ETHNICITY (MĀORI, NON-MĀORI) (APRIL – JUNE 2014-2019)



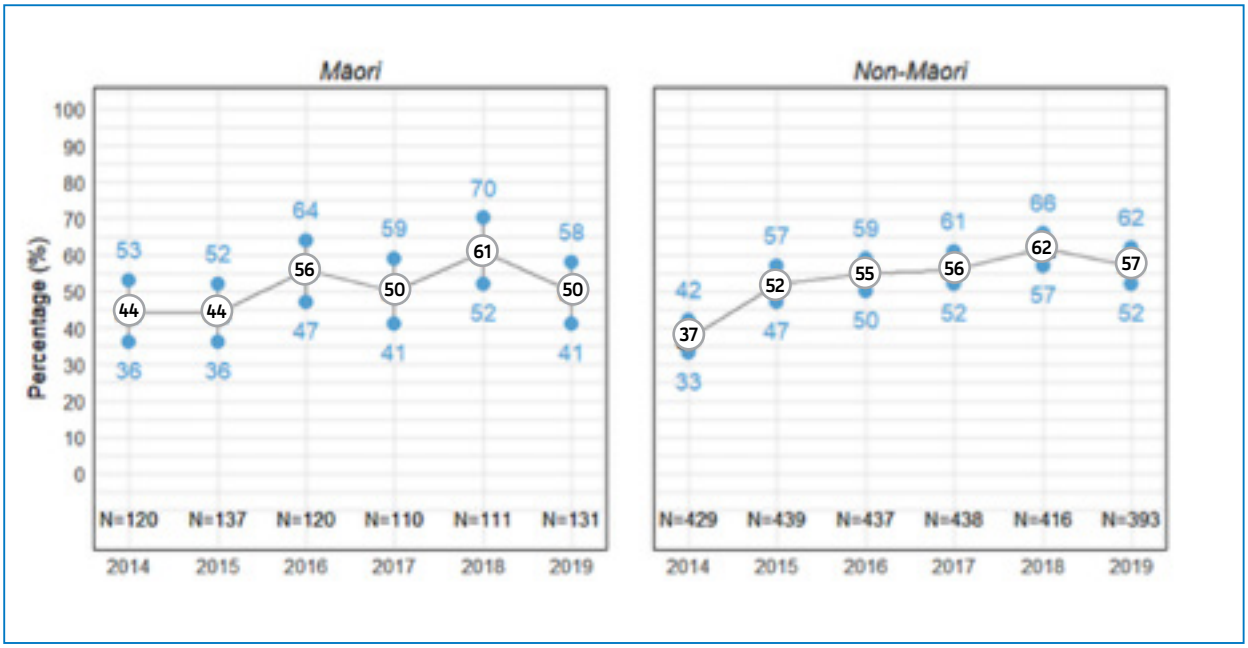
Note: Error bars represent 95% confidence intervals.

FIGURE 39: CHILD ABUSE AND NEGLECT **CONCERN** RATES FOR CHILDREN EVALUATED IN THE EMERGENCY DEPARTMENT BY ETHNICITY (MĀORI, NON-MĀORI) (APRIL – JUNE 2014-2019)



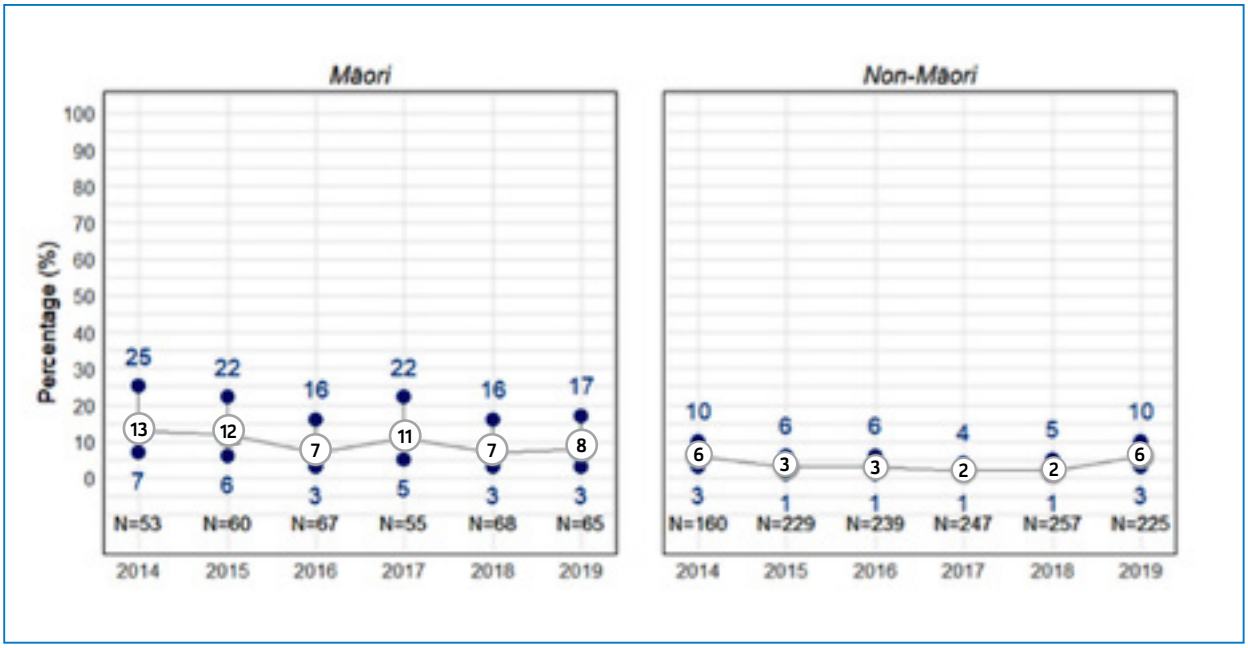
Note: Error bars represent 95% confidence intervals.

FIGURE 40: POST-NATAL MATERNITY INTIMATE PARTNER VIOLENCE **ASSESSMENT** RATES BY ETHNICITY (MĀORI, NON-MĀORI) (APRIL – JUNE 2014-2019)



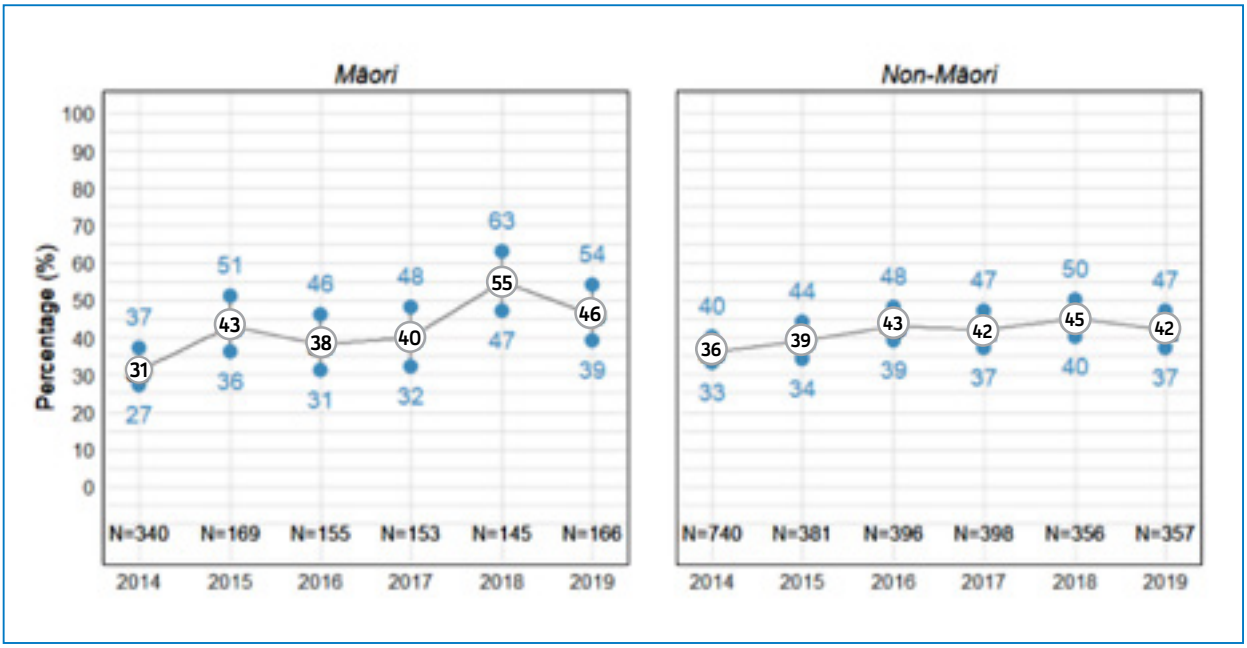
Note: Error bars represent 95% confidence intervals.

FIGURE 41: POST-NATAL MATERNITY INTIMATE PARTNER VIOLENCE **DISCLOSURE** RATES BY ETHNICITY (MĀORI, NON-MĀORI) (APRIL – JUNE 2014-2019)



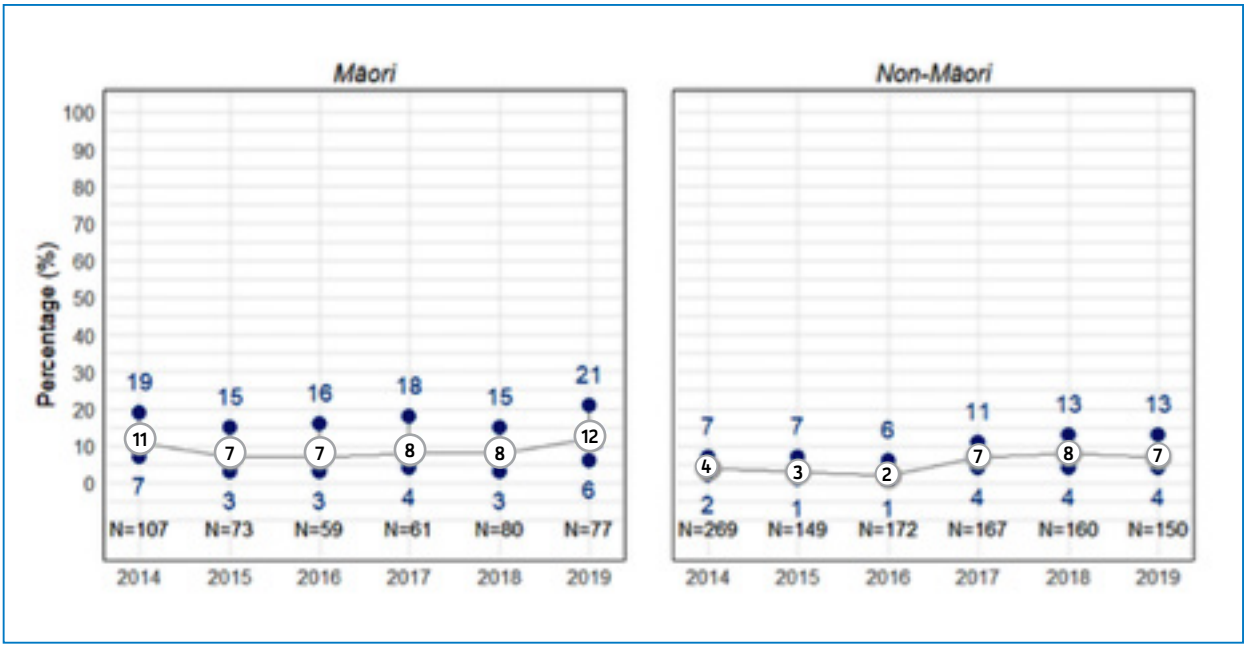
Note: Error bars represent 95% confidence intervals.

FIGURE 42: CHILD HEALTH IN-PATIENT INTIMATE PARTNER VIOLENCE **ASSESSMENT** RATES BY ETHNICITY (MĀORI, NON-MĀORI) (APRIL – JUNE 2014-2019)



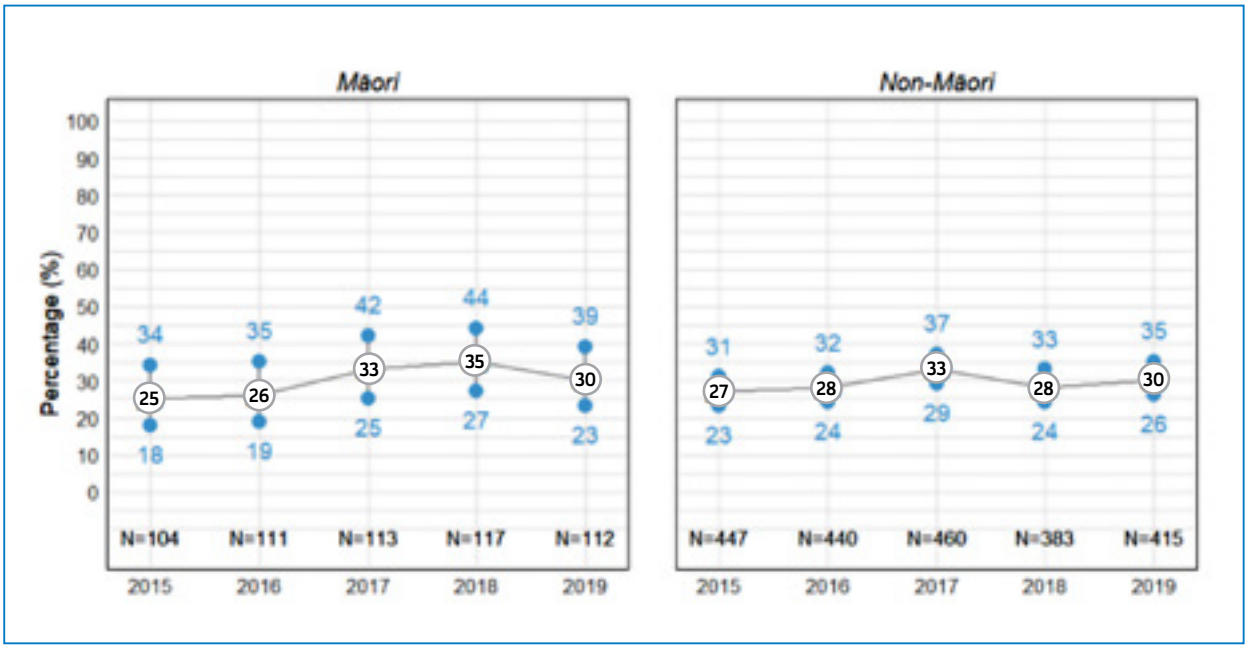
Note: Error bars represent 95% confidence intervals.

FIGURE 43: CHILD HEALTH IN-PATIENT INTIMATE PARTNER VIOLENCE **DISCLOSURE** RATES BY ETHNICITY (MĀORI, NON-MĀORI) (APRIL – JUNE 2014-2019)



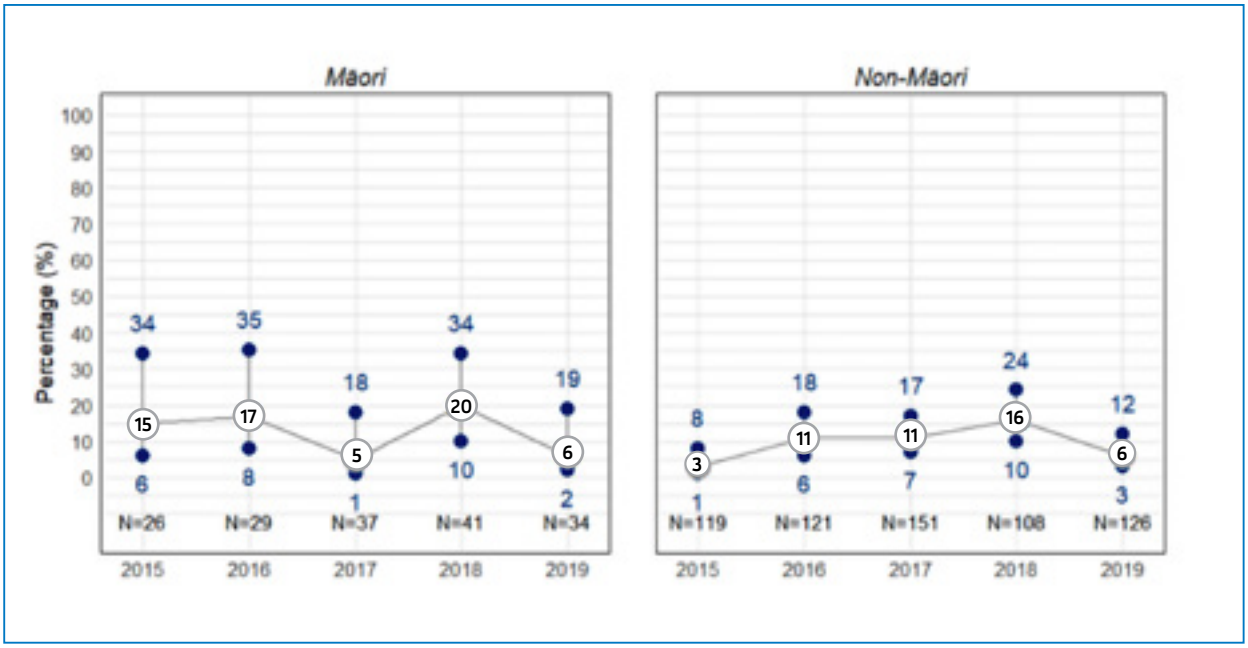
Note: Error bars represent 95% confidence intervals.

FIGURE 44: EMERGENCY DEPARTMENT INTIMATE PARTNER VIOLENCE **ASSESSMENT** RATES BY ETHNICITY (MĀORI, NON-MĀORI) (APRIL – JUNE 2015-2019)



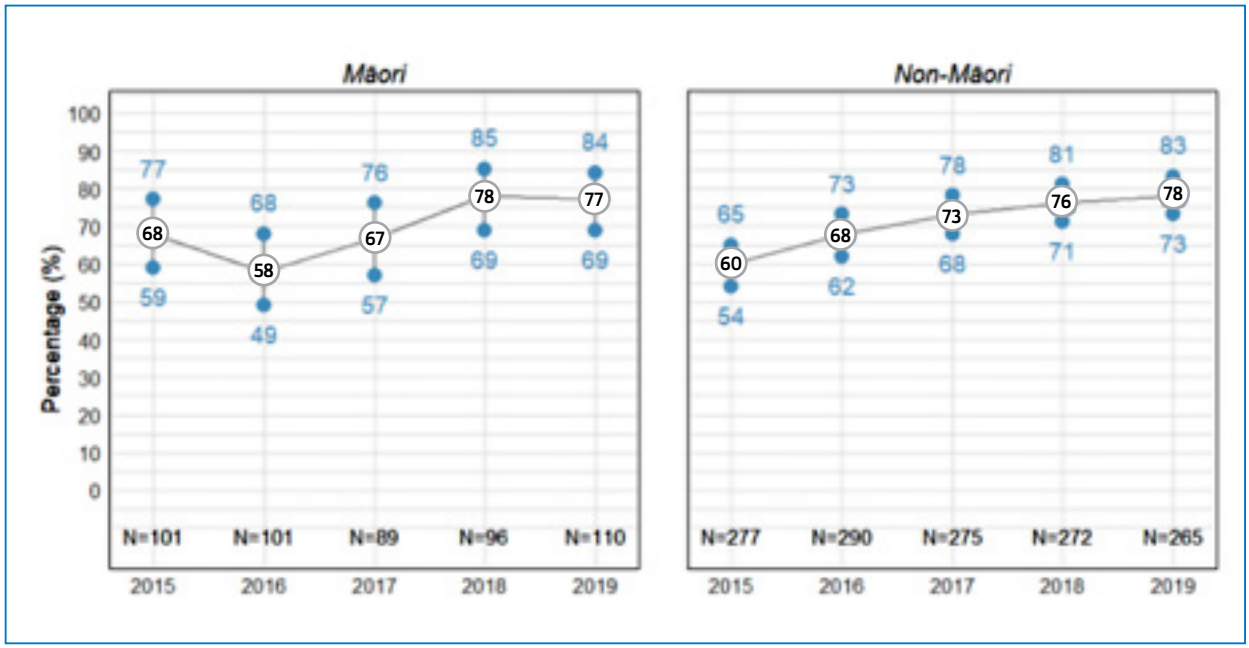
Note: Error bars represent 95% confidence intervals.

FIGURE 45: EMERGENCY DEPARTMENT INTIMATE PARTNER VIOLENCE **DISCLOSURE** RATES BY ETHNICITY (MĀORI, NON-MĀORI) (APRIL – JUNE 2015-2019)



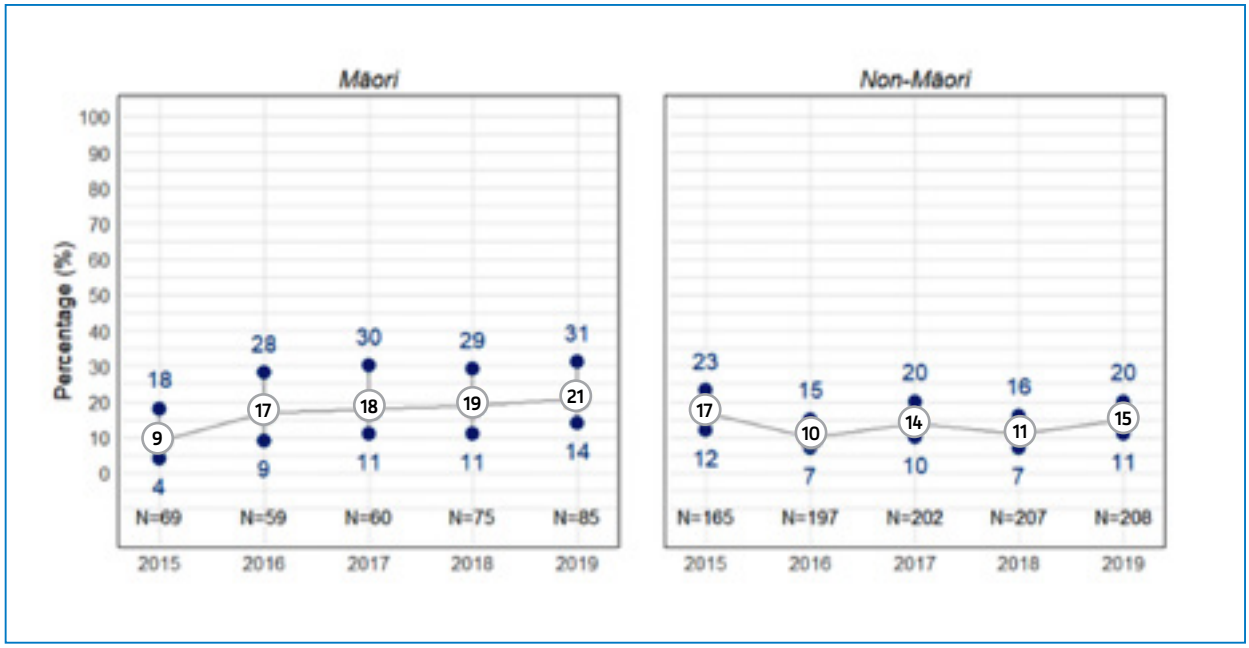
Note: Error bars represent 95% confidence intervals.

FIGURE 46: SEXUAL HEALTH INTIMATE PARTNER VIOLENCE **ASSESSMENT** RATES BY ETHNICITY (MĀORI, NON-MĀORI) (APRIL – JUNE 2015 – 2019)



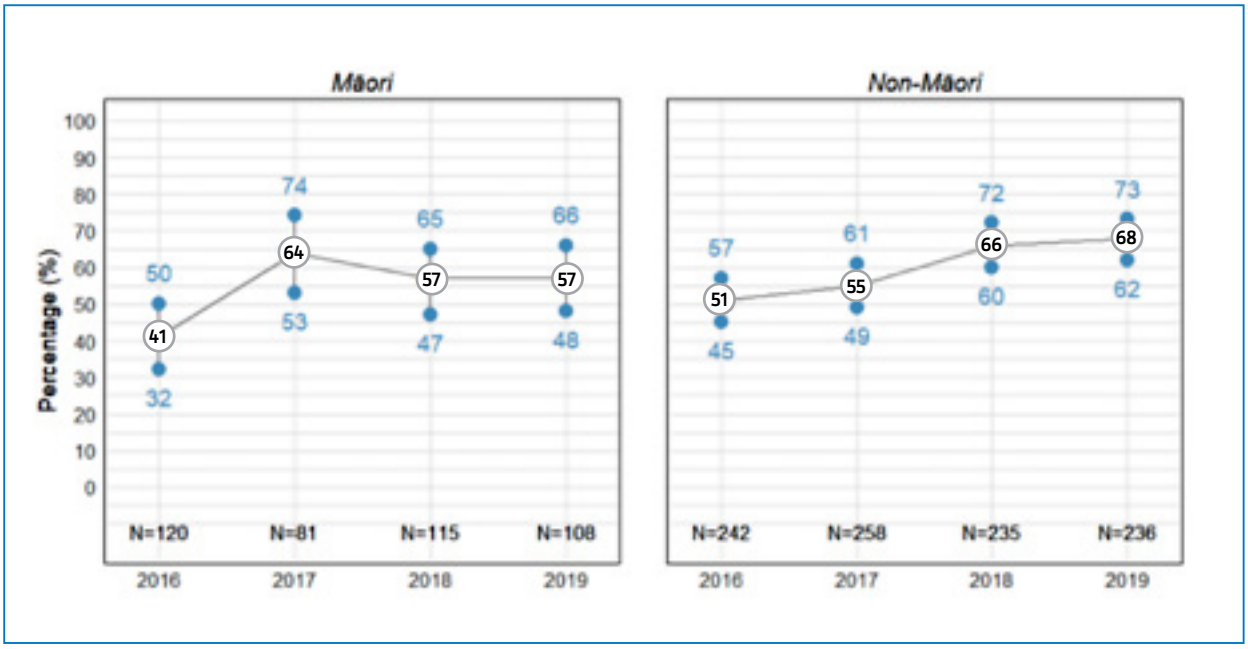
Note: Error bars represent 95% confidence intervals.

FIGURE 47: SEXUAL HEALTH INTIMATE PARTNER VIOLENCE **DISCLOSURE** RATES BY ETHNICITY (MĀORI, NON-MĀORI) (APRIL – JUNE 2015-2019)



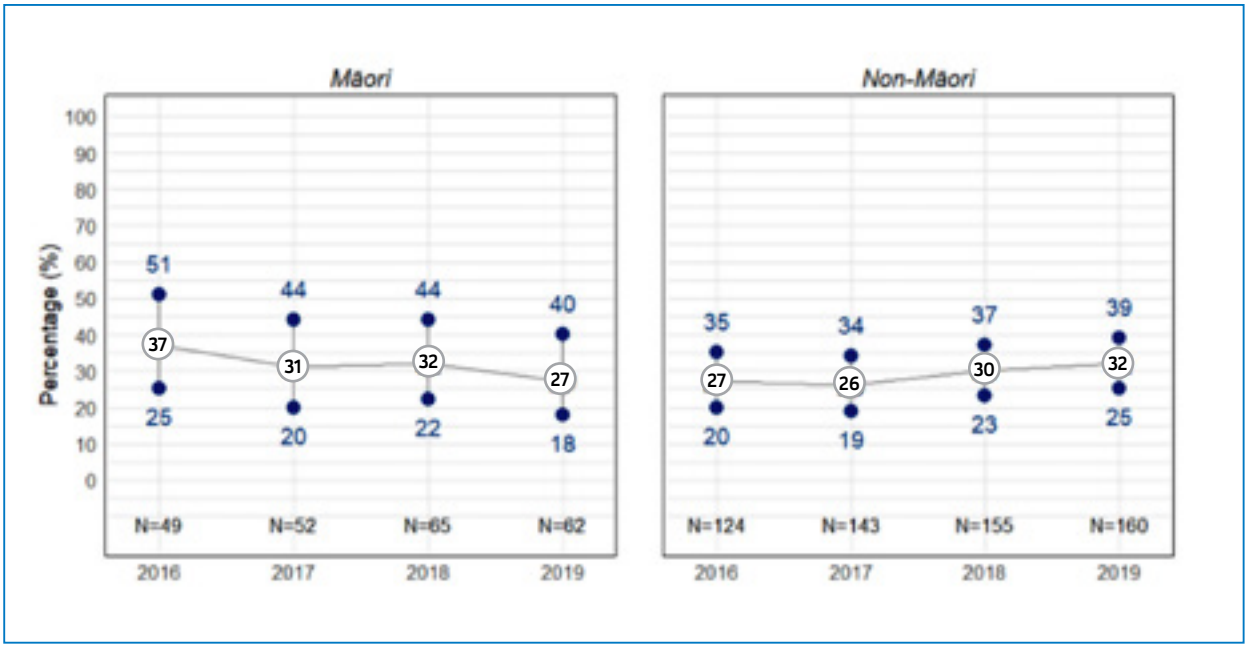
Note: Error bars represent 95% confidence intervals.

FIGURE 48: ALCOHOL AND DRUG INTIMATE PARTNER VIOLENCE **ASSESSMENT** RATES BY ETHNICITY (MĀORI, NON-MĀORI) (APRIL – JUNE 2016-2019).



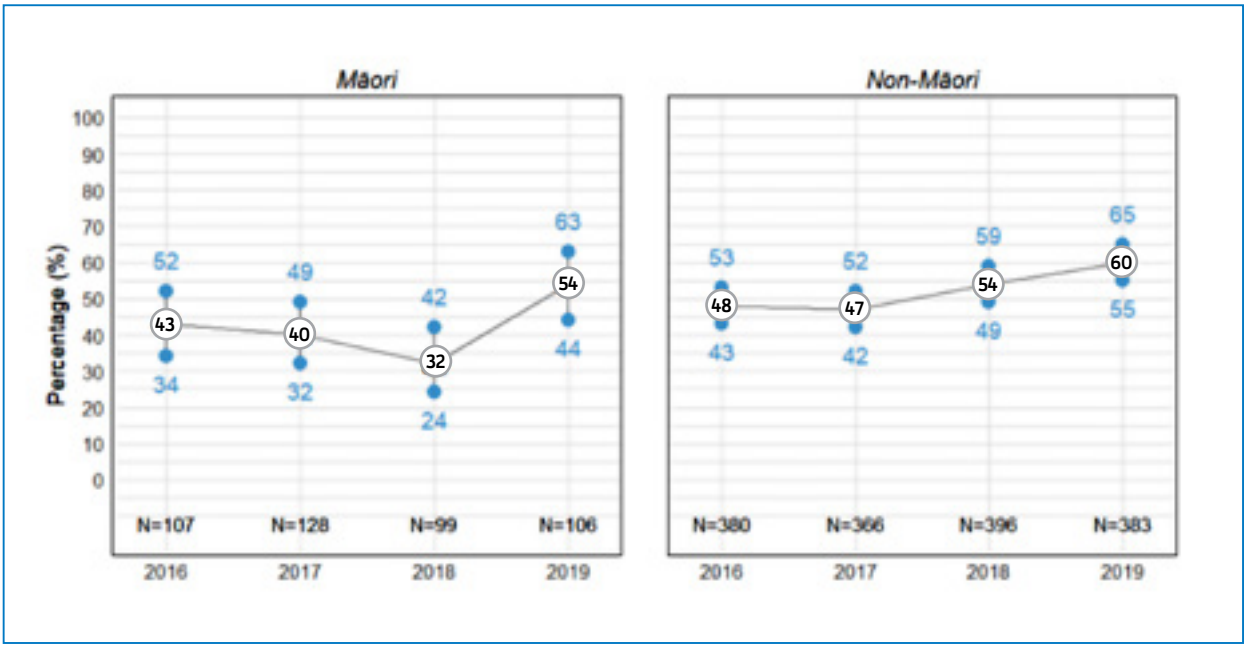
Note: Error bars represent 95% confidence intervals.

FIGURE 49: ALCOHOL AND DRUG INTIMATE PARTNER VIOLENCE **DISCLOSURE** RATES BY ETHNICITY (MĀORI, NON-MĀORI) (APRIL – JUNE 2016-2019).



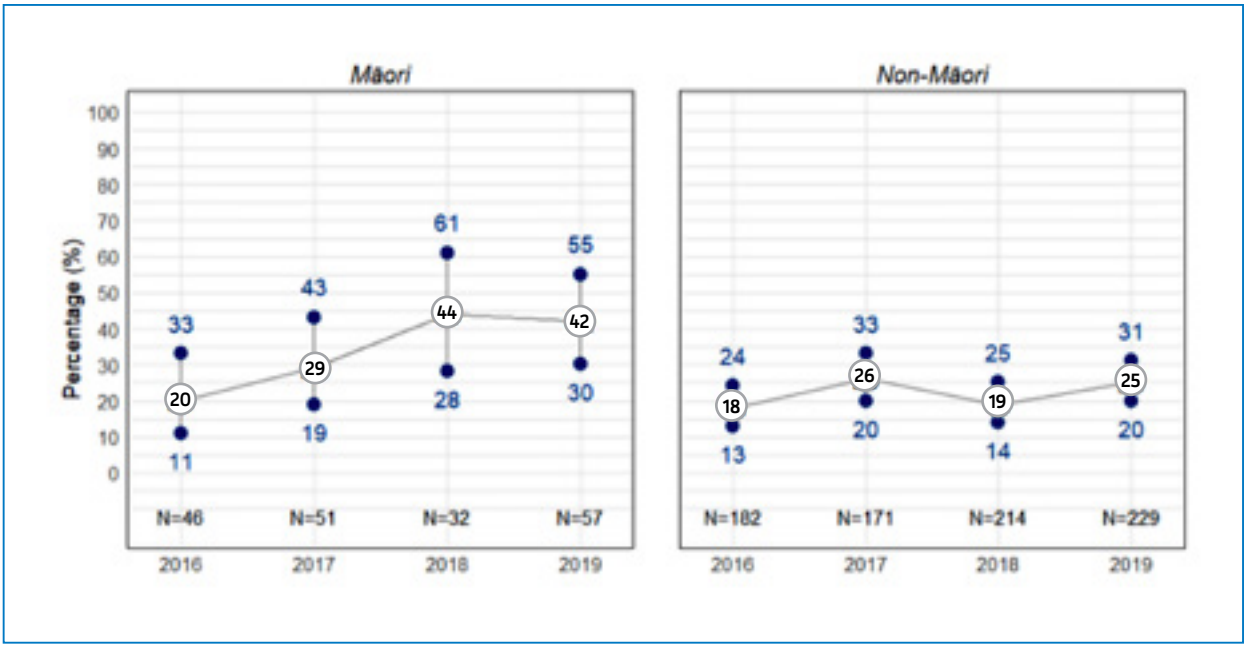
Note: Error bars represent 95% confidence intervals.

FIGURE 50: COMMUNITY MENTAL HEALTH INTIMATE PARTNER VIOLENCE **ASSESSMENT** RATES BY ETHNICITY (MĀORI, NON-MĀORI) (APRIL – JUNE 2016-2019).



Note: Error bars represent 95% confidence intervals.

FIGURE 51: COMMUNITY MENTAL HEALTH INTIMATE PARTNER VIOLENCE **DISCLOSURE** RATES BY ETHNICITY (MĀORI, NON-MĀORI) (APRIL – JUNE 2016-2019).



Note: Error bars represent 95% confidence intervals.

FINDINGS

QUALITY IMPROVEMENT AND PDSA CYCLES

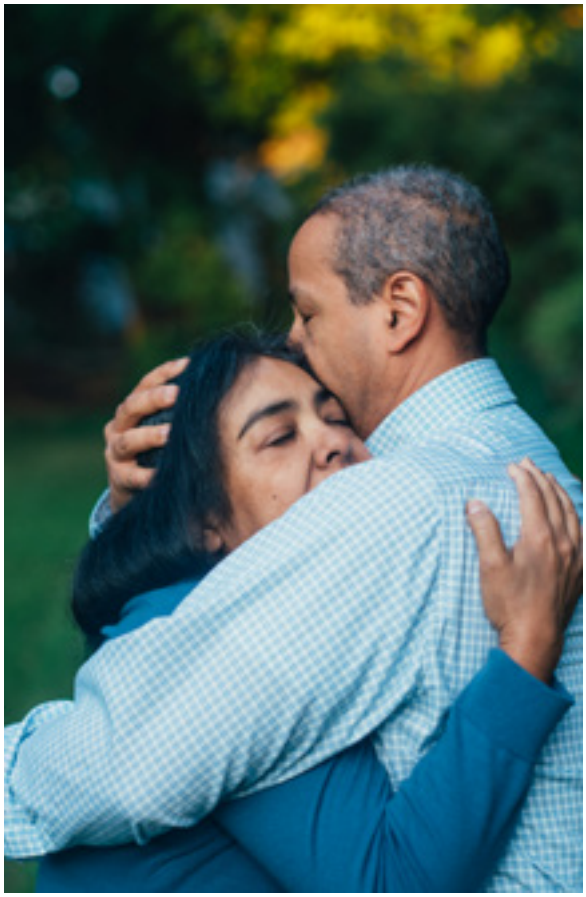
The Model for Improvement PDSA process[12] provides a mechanism to improve the consistency and quality of family violence service delivery. Of the 37 (19 DHBs) PDSA cycle plans submitted, 11 (6 DHBS) were completed within the following four months, documenting diverse system learning. Three PDSA plans did not generate the predicted change, but the system learning informed future actions. The process continues to provide insight into practical barriers preventing assessment and identification and act as small interventions to shift the system in the desired direction. Below are examples of individual DHB learning from PDSA cycles.

Examples of successful change actions included:

- Improving delivery of Shaken Baby prevention education by clarifying the age eligibility criteria
- Refining VIP training to ensure participant needs were met and information duplication reduced
- Increasing use of electronic documentation by rural public health nurses through telephone training support
- Developing actions to remedy identified inaccuracies in intimate partner violence enquiry electronic documentation and low completion rates
- Increasing staff awareness and understanding of VIP following orientation session
- Increasing intimate partner violence enquiry in the emergency department by addressing electronic data input, audit reporting and outstanding staff training issues
- Adopting use of feedback forms to gauge staff satisfaction with VIP refresher training
- Capturing positive intimate partner violence disclosures missed in the emergency department by implementing enquiry in medical wards

Examples of learning for improvement included:

- Referral rates did not improve following implementation of an antenatal MDT, but report of concern quality improved
- FVIC ward visits did not improve IPV enquiry in maternity services
- Child protection checklist postcard prompts did not significantly increase completion rates



DISCUSSION

The New Zealand health system has a critical role in the multisectoral response to violence within families or whānau.[6,18,53] Given the adverse impact on health and wellbeing, health professionals are often the first point of contact for those impacted by violence who can provide a safe environment for disclosure and a supportive response.[6,54] The Violence Intervention Programme largely represents the New Zealand (NZ) health system response to violence within families and whānau directed by national assessment and intervention guidelines[2,55] and supported by a health systems approach.[8,28] VIP is aligned to government initiatives to reduce child abuse and neglect and intimate partner violence and contributes to the whole of government Family Violence & Sexual Violence Work Programme.[3]

The VIP evaluation includes three work streams (1) measuring system infrastructure indicators (2) capturing service delivery snapshots and (3) fostering programme improvements through Plan–Do–Study–Act cycles. The evaluation findings provide services, DHBs, MOH, the VIP management team and other key government departments with information and accountability data regarding VIP implementation. This report focuses on DHB data for the period 1 July 2018 to 30 June 2019.

VIP performance

Internationally, a comprehensive integrated system response is advocated to support effective health professional responses to those impacted by violence.[6,8,17,18] Across the majority of DHBs, this system infrastructure has been established, indicated by strong *Organisational Leadership, Training and Support, Resource Funding, Policies and Procedures, Collaboration and Documentation* domain scores. Yet notably, the domains which involve the practice of intervening (*VIP Practices*) and the monitoring of intervention effectiveness (*Quality Improvement*) remain low performing. This finding is reinforced by clinical audit snapshots continuing to evidence high variation in the quality and consistency of IPV and CAN assessment and disclosure across services and DHBs. In the 2019 audit period, 89% (115/129) of services did not achieve the target assessment and disclosure rates (see Table 6). There is a significant gap between current levels of service delivery and what could be achieved if targets were met. For example, the 2019 national estimate of women seeking care in the emergency department, the setting with highest number of eligible patients seen, who received IPV intervention was 2,300. This compares to the potential 14,222 who would be served with an 80% assessment rate and 15% disclosure rate. **Urgent effort is needed to improve IPV enquiry and CAN assessment, critical in identifying and preventing the adverse health impacts of violence.**

Many DHBs did not submit completed PDSA improvement cycle reports in 2019. However, the process continues to provide insight into practical barriers preventing assessment and identification and act as small interventions to shift the system in the desired direction. Reinstating annual audit site visits would provide opportunity for FVICs to present contextual information influencing programme achievements, providing evaluators with a wider understanding of programme performance both regionally and nationally. Onsite audit visits also provide opportunity to engage DHB VIP leadership in audit challenges and successes.

Improving responsiveness

Despite recognising family violence as a complex problem, solutions often reflect models of linear cause and effect, such as issuing more policy to improve practice.[56-58] While VIP has established significant system infrastructure critical in supporting health professionals to respond to those impacted by violence, this has not translated into practice. Ongoing low assessment and disclosure rates indicate system infrastructure is of limited function when faced with the complexity and uncertainty of responding to the needs of families or whānau. Internationally, leading health systems scholars advocate for adopting new approaches to understanding health systems that are cognisant of adaptive system behaviours.[56,59,60] Recognising the limitations of traditional quality improvement methods, Braithwaite[56] argues 'it's time to stop thickening the rule book, reorganising the boxes on the organisational chart, and introducing

more key performance indicators – and to do something more sophisticated' (p.3). To move beyond frozen system performance and improve health professional responsiveness to those impacted by violence, innovative inquiry is critical. Understanding health professional experiences of the complexity and uncertainty they encounter during practice can call attention to new ways to support responsiveness. For instance, providing opportunities for health professionals to collectively make sense of experiences of high risk and high impact situations and improve organisational capability and capacity in responding.[61] As Goicolea, Hurtig, San Sebastian, Vives-Cases, Marchal[62] state, 'adequate detection of women suffering from IPV is a complex process that requires more than asking questions and following the steps of a protocol' (p.9)

Revisiting VIP programme logic

With significant system learning behind us, it is timely to revisit the VIP programme logic developed in 2002 by the MoH Advisory Committee. New Zealand is currently working toward an 'integrated approach' to family violence service delivery.[63] This involves more than coordination; all agencies and practitioners must have a collective understanding of family violence and the overall response system to respond to those impacted by violence effectively.[53] Ideally, the collective approach brings together multiple perspectives to understand and respond to the complexities sustaining violence within people's lives. This connects the health system to the wider environment that violence occurs within, beyond traditional health system boundaries. The approach therefore has implications for how a family violence intervention within health may be conceptualised and reflected within VIP programme logic. Complex interventions require flexible and dynamic logic models that adapt to context.[64]

2019 VIP evaluation findings indicate further work is needed to develop meaningful, collaborative and reciprocal partnerships with Māori to inform culturally responsive VIP services. Currently, the health system is non-compliant with Te Tiriti o Waitangi and significant health inequities continue to be reinforced through institutional racism.[42,46,65] Given the high prevalence of whānau Māori impacted by violence, it is critically important Māori co-design VIP services to address the needs of whānau and contribute to delivering equitable health outcomes for Māori.[46,46,49,65,66] Ideally, meaningful partnership with Māori would be modelled in the national VIP programme.

What we measure influences how we view and respond to the problem. To date, VIP has focused on supporting health professionals. Better understanding of impact for service users, particularly for Māori is overdue. While gathering the lived experience requires sensitivity, it is critical to understand people's journey through the health system[67] as they seek assistance supporting safety and wellbeing for themselves and their children, whānau or family. Understanding this experience and the individual contexts VIP intervention takes place within can improve the quality of the health system response. Without this understanding, we risk repeating unhelpful and potentially harmful responses to those seeking help in times of crisis.[50] Inquiry into the experiences of families and whānau is also necessary in understanding how VIP impacts communities and delivers on the 'better outcomes' theorized within VIP programme logic and the government Statement of Intent.[19] As Bouckaert and Halligan[68] note, 'the more quality that is taken into account, the more valid the performance measurement system will be' (p.87). An understanding of system outcomes widens understanding of programme performance, reshaping choices of measurement and understanding of the problem.[68]

Strengths and Limitations

The VIP evaluation is one of the six system components. Over time, evaluation processes have facilitated individual DHB programme management planning and provided the Ministry the ability to target remedial actions in the context of limited resources. Evaluation procedures are based on a philosophy of supporting programme leaders in building a culture of improvement.[12,27] The project promotes a comprehensive systems approach to addressing family violence, a key characteristic for delivering effective services.[6-8] Strengths include using established family

violence programme evaluation instruments and following standard quality improvement processes in auditing.[12,69] The audit round fosters a sense of urgency[70] supporting policy revisions, procedure endorsements and timely filling of Family Violence Intervention Coordinator position vacancies. Finally, and perhaps most importantly, the longitudinal nature of the evaluation has allowed monitoring of change over time. Clinical snapshot audits provide standardised data aggregated across DHBs for accountability and performance measurement.

Limitations are important to consider in interpreting the findings and making recommendations based on this evaluation work. By design, this study is limited to acute hospital and community services at main DHB secondary and tertiary public hospitals. The VIP does not include services provided by DHB satellite hospitals, private hospitals which may also provide publicly funded services, or primary care where family violence prevention programmes are being introduced opportunistically in DHB regions.[71,72] VIP limitations continue such as gaps in addressing the health response to men who use violence,[73] or others who have a pattern of using controlling, coercive behaviours.

This evaluation reports on the second application of the revised Delphi audit tool. Self-report methods likely introduce some error. In past evaluations where both external and self-audits were conducted a pattern of over-reporting by DHBs was noted. Continuing external audits would reduce error and provide a strengths-based positive team approach to improvement. While clinical snapshots are important to monitor service delivery, there are some important limitations to be aware of. These include:

- The snapshot does not capture all recommended family violence assessment and intervention, such as for male patients presenting with signs or symptoms indicative of abuse or services provided within primary care settings.
- The snapshot sample size for individual DHBs is small (n=25) and are captured within a specific timeframe (April- June). For example, a DHB may have assessed for abuse in 15 out of 25 eligible cases (60%) with a single abuse disclosure (1/15, 6.7%), with increasingly wide confidence intervals. Individual DHB estimates are therefore considered indicative of service delivery.

- The snapshot monitors a limited number of service delivery indicators, sensitive to the burden of manual medical record review. Not captured, for example, is the graduated health response based on assessed level of risk.

VIP Priorities

- **Undertake urgent work to improve VIP assessment and disclosure rates**. This will involve innovative inquiry to understand health professional experiences of engaging with those impacted by violence as well as service user experiences of the VIP intervention.
- **Support the development of collaborative and reciprocal partnerships with Māori** to inform VIP policy and improve VIP service delivery.
- **Review VIP programme logic** to align with current cross-government work on integrating family violence systems.

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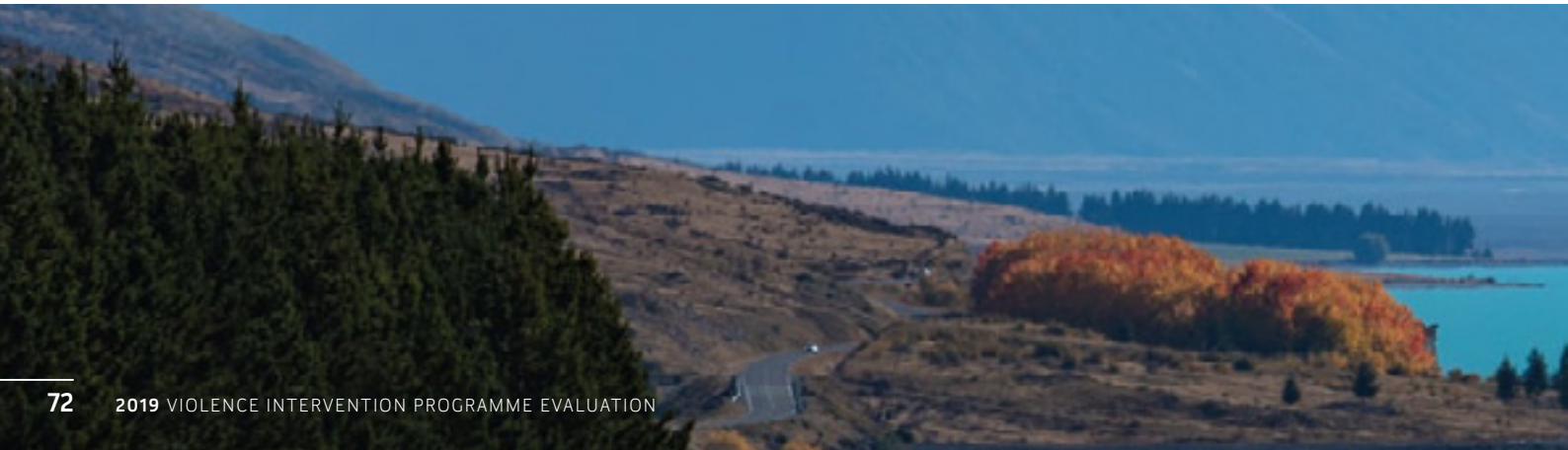

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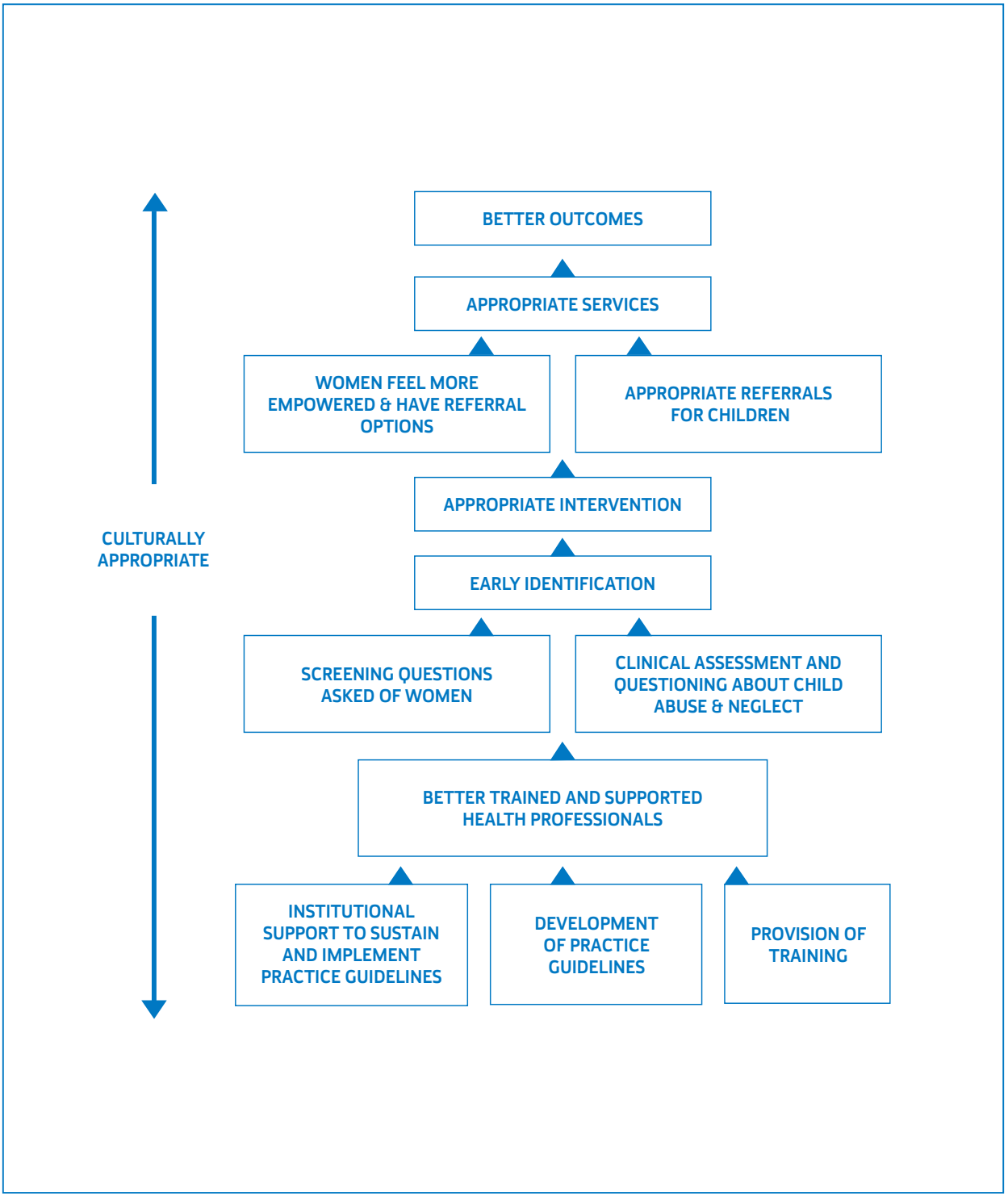
APPENDICES

APPENDIX A: FAMILY VIOLENCE PROGRAMME LOGIC



Family Violence Programme Logic

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

APPENDIX B: DATA LOCATIONS[1]

DHB	Hospital
Auckland	Auckland City Hospital; Starship Children's Hospital
Bay of Plenty	Tauranga Hospital; Whakatane Hospital
Canterbury	Christchurch Hospital
Capital & Coast	Wellington Hospital
Counties Manukau	Middlemore Hospital
Hawke's Bay	Hawke's Bay Hospital
Hutt Valley	Hutt Hospital
Lakes	Rotorua Hospital
MidCentral	Palmerston North Hospital
Nelson Marlborough	Nelson Hospital; Wairau Hospital
Northland	Whangarei Hospital
South Canterbury	Timaru Hospital
Southern	Dunedin Hospital; Southland Hospital
Hauora Tairāwhiti	Gisborne Hospital
Taranaki	Taranaki Base Hospital
Waikato	Waikato Hospital
Wairarapa	Wairarapa Hospital
Waitemata	Waitakere Hospital; North Shore Hospital
West Coast	Grey Base Hospital
Whanganui	Whanganui Hospital

VIP EVALUATION INFORMATION PACK 2019

1. Overview

1.1 Evaluation activities

The VIP evaluation provides the opportunity for DHBs to build competence in family violence service delivery as well as measure progress over time. It is an opportunity to identify programme strengths and opportunities. Processes are guided by a philosophy of supporting programme leaders in building a culture of improvement.

The evaluation project is approved by the Multi-region Ethics Committee (AKY/03/09/218/AM07) with current approval to 4 December 2020.

The 2019 VIP evaluation includes three activities (see table below). This document outlines each activity in more detail.

Evaluation Activity	Audit period	Measuring	Tool	How to submit	Due date*
VIP Delphi self-audit	1 July 2018 – 30 June 2019	System infrastructure	Revised Delphi Self-Audit Tool (Excel workbook to be completed)	Email completed tool to Arlene Advani	04 October 2019
VIP Snapshot clinical audits	1 April 2019 – 30 June 2019	Accountability	Random sample of 25 records in 7 services (VIP Snapshot website)	Completed on-line Snapshot	04 October 2019
PDSAs	On-going	Quality improvement	Two PDSA worksheets – emailed to audit team to review	Email worksheets to Arlene Advani	04 October 2019 (PLAN only) 09 December 2019 (completed PDSA worksheets)
• Please contact Arlene Advani if an extension is needed.					

1.2 Evaluation reporting and feedback

Feedback and evaluation reporting to DHBs will occur as follows:

- The Ministry expect that the Delphi and Snapshot audit findings, submitted to AUT, will be referenced in the January 2019 DHB Performance Monitoring Report.
- Individual DHB Snapshot and Delphi self-audit reports provided by auditors will be kept confidential between the DHB and MOH VIP team.
- A summary of the findings will be presented at the National Network of Violence Intervention Programme Coordinators. DHBs that achieve programme evaluation targets will be named in the national report.
- Evaluators are available to attend regional FVIC meetings if required to present and discuss evaluation processes or findings.

1.3 Support for your evaluation

Evaluation support is available through various means. Regional family violence intervention coordinators should be your first point of contact. Please also feel free to get help from the evaluation team at www.aut.ac.nz/vipevaluation or contacting:

- Arlene Advani for queries on submitting the evaluation forms or accessing the Snapshot website. Arlene can be reached on arlene.advani@aut.ac.nz and (09) 921 9999 ext. 7153
- Brice Shun is our data manager. He will follow up should there be any issues in data entry. He will be working limited hours on the project.
- For concerns regarding the process or conduct of the audit please contact Professor Jane Koziol-McLain (principle investigator) at jkoziolm@aut.ac.nz or (09) 921 9670 or the Ministry of Health contact person, Helen Fraser (07) 929 3647 or Helen_Fraser@moh.govt.nz.
- Please send general email queries to vip-eval.ac.nz

Evaluation team members from the Centre for Interdisciplinary Trauma Research, School of Clinical Sciences, Auckland University of Technology:		
Arlene Advani Administrator (09) 921 9999 x7153 aadvanni@aut.ac.nz	Brice Shun Data Manager brice.valentin.kok.shun@aut.ac.nz	Professor Jane Koziol-McLain, PhD, RN Evaluation Lead (09) 921 9670 jkoziolm@aut.ac.nz

Your VIP evaluation plan

The VIP evaluation process includes planning the evaluation, conducting it, analysing (or studying) the results and acting on the findings. We encourage you to develop a plan to guide the evaluation processes ideally in collaboration with the DHB VIP portfolio manager, steering group (including Quality & Risk and Māori Health Unit) and Family Violence Intervention Coordinator(s) (FVICs).

We suggest you read through the information on each evaluation activity to help you plan the audit process.

2.1 Planning for the audit (PLAN)

In creating a plan, you may find the table below helpful. Once you are clear on the process, engage with the audit team and sign off.

Questions to help you plan your audit	**Notes:**
Have you read through the information and requirements for Snapshot clinical audit, Delphi self-audit and the PDSA worksheet?	
Do you have a timeline to conduct the audit and analyse the results?	
Who are the audit team members?	
Do you have adequate resources and support (such as Quality and Risk, Clinical Records, Māori Health, IT, administration support)?	
Who will complete each audit activity, and are they clear on the process to follow?	
When will the results be analysed and who will analyse them?	
How will you share audit findings and who will you share them with (including VIP Steering Group, MoH portfolio manager, AUT evaluation team)?	

2.2. Conducting the audit (DO)

- The first step in conducting the evaluation is to communicate the plan, responsibilities and timeline to the DHB audit team members. Please note that the Delphi audit tool requires a senior manager responsible for VIP to complete some of the items.
- The second step is to gather the data required – clinical records for the snapshot and various pieces of evidence for the self-audit (see each section for more detail).
- Complete the audit documentation which includes the Snapshot clinical audits and Delphi self-audit tool.
- Ask for help as needed – your IT team may be able to help you with technical difficulties or you can reach out to you DHB audit team, quality improvement manager, VIP manager or the AUT evaluation team.

2.3 Analysing your audit data (STUDY)

The benefit of the evaluation process is using the data to identify the strengths and opportunities for enhancement and development with your violence intervention programme. This is not only about compliance but seeing the areas of programme input (the Delphi self-audit) and outcomes (the Snapshot data) that you want to acknowledge as well done, or improve upon. The evaluation data can be used to prioritise actions to be taken in collaboration with the audit team members and VIP advisory group. From this, two PDSA (Plan, Do, Study, Act) activities can be prepared.

2.4 Acting on the findings (ACT)

Review the implemented follow-up actions of the audit process and PDSAs. Check for effectiveness of the plan and efficiency in making changes. If necessary amend the PDSAs and the audit process to help you prepare for the next evaluation process.

The VIP Delphi self-audit

Update your **VIP Delphi self-audit tool (revised, 2018)** for the one-year period 1 July 2018 to 30 June 2019 (make sure to rename the file). In this section we:

- Answer frequently asked questions (FAQs) on the Delphi tool
- Explain how to gather information
- Outline who is responsible for completing the items
- Describe how to complete the tool

3.1 FAQs on the Delphi self-audit tool (revised, 2018)

1. **What is the Delphi self-audit tool?**
    a. The Delphi tool was introduced to measure health infrastructure indicators that support a consistent and quality response to family violence. It provides an external standardised evaluation and enables DHBs to benchmark themselves against each other and best practice over time. It identifies DHBs and areas of DHB VIP infrastructure in need of support.

2. **What is the aim of the Delphi tool?**
    a. To be aspirational, highlighting areas for development and improvement.
    b. Simple to complete with as few items as necessary.
    c. Reflect the IPV and CAN integrated programme approach to family violence in a single integrated VIP audit tool.
    d. To align with the 2016 MOHVAIG.
    e. To provide a benchmark for DHBs to measure themselves against.

3. **What support will DHBs receive from the external auditor?**
    a. In 2019, you may access support through AUT's Centre for Interdisciplinary Trauma Research. You can contact Jane.Koziol-McLain@aut.ac.nz or (09) 921 9670. Arlene.Advani@aut.ac.nz or (09)921 9999 ext 7153 will be able to provide you with help on evaluation documents and accessing the online Snapshot system.
    b. Evaluators are available to attend regional VIP Coordinator meetings.
    c. Funding for external site visits for future audits is being considered.

4. **Will I still need an evidence folder?**
    a. Part of the audit requires evidence to support the ratings on the evaluation. Therefore, it will be important that you have evidence available to support your rating and the feedback you provide. We recommend that supporting evidence, as detailed in the tool's evidence column, is collated and easily accessible.

5. **What happens if I am *almost there* on an item (e.g. meet it 75% but not completely)?**
    a. Most of the items are scored "Yes" or "No". On some items, your VIP may almost be a "Yes" score but not quite. In this situation you should select "No" remembering that the tool is aspirational and the "No" rating serves to highlight areas for future focus, development and enhancements for the programme.

6. **What will my score look like?**
    a. Based on the findings of the first round, the target Delphi score is 80.
    b. The tool has new domains and indicators that were determined by panellists as important for health system response to family violence. It is likely to take time to have these elements of the programme infrastructure implemented.

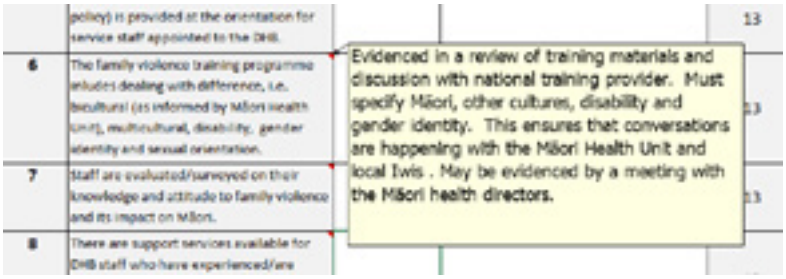
3.2 How to gather evidence for the Delphi self-audit?

3.2.1 What evidence is required?

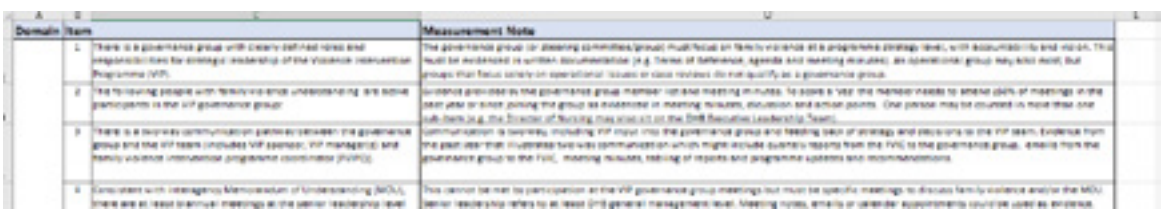
Evidence is required to support scoring throughout the Delphi self- audit tool. As you read through the audit tool items and measurement notes, you will be able to identify what evidence is needed.

The measurement notes appear in the audit tool when you hover your mouse over the item (see example below).

Hover over the red triangles to view measurement note notes



There is also a separate sheet at the back of the audit tool workbook called 'Measurement Notes' that lists all the items and measurement notes. This can be printed out to help you complete the tool.



3.2.2 Where will you find the evidence?

Listed below is a range of documents that might be helpful to you in completing the Delphi self-audit tool. The list is not exhaustive as there may be other documentation that will help.

- All written policies, protocols and procedures relevant to family violence (intimate partner violence & child abuse and neglect) and relevant department-specific policies and procedures regarding family violence e.g. security policy, interpreter policy.
- Documentation of the DHB's family violence governance, advisory or steering group(s) including:
    - Roster of participating individuals, departments, and agencies
    - Terms of reference
    - Schedule of meeting dates
    - Meeting agendas, minutes or notes
- Any documents relating to policies, protocols, procedures, or services for Māori and non-Māori /non-Pakeha (e.g., Asian, Pacific Peoples, Lesbian, Gay, Bisexual, and Transgendered) women and children.
- Formal training plan, communications with the National VIP training, schedules of planned trainings for employees and attendance lists.
- Standardised forms or checklists (electronic or hard copy) used for family violence programmes including:
    - Domestic violence routine enquiry forms
    - Assessment, intervention and referral forms
    - Consent to photograph forms for family violence cases
    - Intervention checklists for staff to use when victims are identified
    - Child abuse and neglect referral forms
- Information on quality improvement activities (refer to VIP Quality Improvement Toolkit) such as:
    - Assessments of staff attitude and knowledge of family violence
    - Chart audits to assess for family violence routine enquiry, assessment and intervention
    - VIP PDSA plans
    - Other documented quality improvement activities
- Documentation of any collaborations/links with community organisations and government agencies (e.g Memorandum of Understanding the Police and Oranga Tamariki) for the purposes of governance, training, programme development, or service delivery
- Information on financial resources that the DHB provides for the family violence programme, including funding specifically for Māori initiatives (Whānau Ora), training, etc.
- Information on support services (e.g. Employee Assistance Programme) for employees who are victims or perpetrators of domestic violence
- Copies of brochures, pamphlets, or referral cards for victims of family violence and the public in the hospital

PLEASE REFER TO MEASUREMENT NOTES REGARDING REQUIREMENTS FOR SPECIFIC ITEMS

3.3 Who completes the Delphi self-audit?

Most of the domains and items will be completed by the DHB's FVIC and/or the VIP Manager. However, two domains and some further items are to be completed by the most Senior Manager responsible for the VIP (e.g. the VIP Sponsor). This is because they are more likely to have access to the evidence required, and the items concern senior management support and leadership for the VIP. Therefore, please ensure the relevant domains and items, and any supporting evidence that you do have, is provided to them in order to complete the tool.

- The domains to be completed by the Senior Manager responsible for VIP are:
  - Domain 1 - Organisational Leadership (all items)
  - Domain 3 - Resource Funding (all items)
  - Domain 6 - Quality Improvement (items 1, 8)
  - Domain 8 - Collaboration (items 2, 4.1)

3.4 How to complete the Delphi self-audit?

The Delphi self-audit tool is an excel macro enabled worksheet. It is accessible on our family violence project evaluation family violence project evaluation web-site (www.aut.ac/vipevaluation) and on the HIIRC VIP site. The following may help you in managing the file:

- You need access to excel to complete the tool and need to '**enable macros**' to use the tool (there are clear instructions on the 'Instructions & Help' page).
- Log-in to the HIIRC VIP site to access additional resources and links as you work your way through the audit tool.
- Print off the 'Measurement Notes Summary Page' if you would like a printed copy of all the measurement notes.
- Collate evidence of all achieved indicators.
- Reference evidence location (such as policy title, date and page number) in the evidence columns.
- Please double check that all items have been answered.
- Enter your name, DHB (from drop-down list) and date on the 'Evaluation Results' page.
- Save the completed tool with the **DHB name and date**.
- Please submit your completed VIP Delphi self-audit to Arlene Advani (Arlene.advani@aut.ac.nz) by 04 October 2019.

VIP Snapshot clinical audit 2019

The VIP Snapshot clinical audit's primary purpose is to provide measurement data of DHB VIP Intimate Partner Violence (IPV) and Child Abuse and Neglect (CAN) assessment and intervention delivery in selected services. The audits are nationally standardised to measure service delivery and inform improvements in the delivery of services to vulnerable children and women, whānau and families.

4.1 What data is required?

We recommend you advise your Quality Manager, Clinical Records or technology (intelligence) support as soon as possible of the audit requirements for each of the 7 services (specified below). They will need to identify the eligible population, then draw retrospective random samples of 25 patient health records from the 3-month review period (1 April to 30 June 2019).

4.1.1 Included services

Seven DHB services are to be included in the 2019 VIP Snapshot audit (see next section for service details). Six for IPV and one service for CAN.

Intimate Partner Violence (IPV) services:

1. Postnatal Maternity inpatient
2. Emergency Department
3. Child Health inpatient (aged 0-16 years) - female guardians, parents or caregivers assessed for IPV
4. Sexual Health
5. Community Mental Health
6. Alcohol & Drug

Child Abuse and Neglect service:

7. Emergency Department: All children aged under two presenting to Emergency Department for any reason

4.1.2 Sites

Audit main DHB sites only. Please do not include satellite sites.

4.1.3 Audit period

The 3-month Snapshot audit period is from **1 April 2019 to 30 June 2019**.

4.1.4 Due date

The audit data should be entered by **04 October 2019.**

4.2 How to complete the Snapshot?

4.2.1 Accessing the Snapshot URL

- Access to the Snapshot system at https://vipsnapshot.aut.ac.nz
    - If you are a new user, please contact Arlene Advani (arlene.advani@aut.ac.nz) to organise registration and passwords for new users. You will be issued with a temporary password and will be required to create a password for the system
    - If you have forgotten your password, please log-in using your DHB user name. The system will ask if you have forgotten your password and issue you with a temporary one. You will be required to create a password for the system.
- Users will be able to save and edit data and receive their audit results in real time.

4.2.2 Selecting a random sample

The first step in selecting a random sample is to identify all eligible persons during the review period (1 April – 30 June 2019) for each of the seven services listed above. You will be asked to enter **this total number** of eligible women / children by service in each audit. In research terms, this is the 'sampling frame'. From those eligible, random samples of 25 patient health records are to be retrospectively selected for each service.

The Quality Manager, Clinical Records or IT Help should be involved in identifying the number of eligible persons and selecting the random sample. Refer to the HIIRC VIP Tool Kit document 'How to select an audit sample'.

Definitions

Detailed definitions for the samples are provided in the next section. They are also available in the Snapshot system drop-down menu.

Adhoc and official audits

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

Starting a new 2019 audit

1. Click on the **+ New Audit** button.
2. Click whether an Official (required Snapshot) or Adhoc (voluntary) audit.
3. Select your DHB from the drop-down list (DHBs are ordered north to south).
4. Enter the percent of current staff who have completed VIP core training by profession (e.g. doctor, nurse, midwife, social worker). You will have reported this in your most recent report to the Ministry of Health.
5. Enter the total number of eligible women / children who were admitted during the audit period.
    a) Please see definition of *'eligible women / children'* in the detailed definitions (it is not the sample number of 25 patients).

b) It is from the '*eligible women / children'* number that 25 patients should be randomly selected.

6. Click 'save' to advance to patient data entry.

4.2.6 Entering patient data

1. Ethnicities
    a. Select ethnicity or ethnicities as recorded in the patient file.
2. IPV Screen (Routine Enquiry) / Child Protection Screen (Risk Assessment)
    a. Select for the patient 'Yes' or 'No'
        i. If tick 'No', save and move on to next patient file.
        ii. If tick 'Yes', go to IPV Disclosed / Child Protection Concern
            1. If tick 'No', save and move onto next patient file
            2. If tick 'Yes', go to IPV Referral /CAN Consultation
                a. Tick 'Yes' or 'No', save and move onto next patient.
3. The number of files entered and saved appears on the right side of the screen. Twenty-five (25) patients' data are to be entered for each service.
4. The 'Official' audit (required Snapshot audit) may need to be manually switched over by clicking the 'In Progress' button to 'DONE' when complete. This is the same process as for the 'Adhoc' (voluntary) audits.
5. Data can be entered in one or more sittings. The system will keep track of how many patients you have entered. Please save your results at the end of each sitting.
6. If you are entering a smaller number of cases for an 'Adhoc' audit you may click the 'In Progress' button to change to 'DONE'.

Your results

The system will provide the DHB results:

- IPV routine enquiry, disclosure and referrals
- CAN assessment, concern and consultation

Document your results for each service in your January 2020 report to the Ministry of Health.

4.3 What are the service specifications and definitions?

4.3.1 Generic questions:

- 'VIP Core Training'
    - Enter the percent of current staff who have completed VIP Core Training in designated service
- 'Ethnicity'

- Select ethnicities as indicated in patient file

- 'Total number eligible'
  - Total number of women (or children) who meet eligibility criteria for the specific service during audit period. See specific service below for criteria.

4.3.2 IPV routine enquiry, disclosure and referral

IPV Routine enquiry

Was the woman asked routine enquiry questions about IPV occurring in the past 12 months?	
NO:	• There is no documentation that the woman was asked routine enquiry questions. If there is documentation regarding a reason for not asking routine enquiry questions (such as 'with partner'), this is still a 'NO'. • **Note**: In Child Health inpatients, the female parent, guardian or caregiver is assessed for IPV. If no female caregiver, the IPV routine enquiry is a 'NO'.
YES:	• There is documentation that the woman was asked routine enquiry questions about IPV occurring within the past 12 months ***or*** the woman self-disclosed IPV. • This would include asking the woman three or more routine enquiry questions about IPV. *The FVAIG (2016) recommend four routine enquiry questions should be asked and the rationale for this is explained (MoH FVAIG P53-54).* • We recognise that some IPV case identification occurs by referral sources (e.g. brought to ED by police with IPV related injuries). In these cases, we assume there is an assessment re the disclosure and therefore routine enquiry should be ticked as a 'YES'.

IPV Disclosure

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

IPV Referral

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

YES: (Active)	• Direct referral to timely access for support by a family violence trained specialist who can provide the victim with danger assessment, safety planning and access to community services. (The trained specialist may include for example, police, social worker, or family violence advocate.)
YES: (Passive)	• Evidence in notes of appropriate referrals to specialised family violence support. This would include, for example, providing the woman with a brochure with contact information.

4.3.3 IPV service specific information

Postnatal Maternity	
Eligibility criteria	• Women who have given live birth and who have been admitted to postnatal maternity ward during audit period.

Emergency Department	
Eligibility criteria	• The number of visits by women aged 16 years and over who presented to ED during the audit period.
Age	• Age of woman
Triage	• Select triage status 1, 2, 3, 4, or 5
Admitted to ICU, coronary care or high dependency unit	• Select 'Yes' or 'No'
Sexual Health	
Eligibility criteria	• Women aged 16 years and over who present to Sexual Health Services during the audit period.

Child Health Inpatient	
Eligibility criteria	• Child health admissions aged 16 years and under, admitted to a general paediatric inpatient ward (not a specialty setting) during the audit period
No female caregiver	• Documentation states there is no female caregiver. If there is no female caregiver, the response to IPV routine enquiry question is 'NO'.
Age of child	• Enter child's age at last birthday. Please enter '0' for children under 1 year

Ethnicity/Ethnicities	• Select as indicated in the child's file
IPV routine enquiry	• Was the female caregiver (parent, guardian or caregiver) asked routine enquiry questions about IPV occurring in the past 12 months?

Community Alcohol & Drugs	
Eligibility criteria	• All new referrals of women aged 16 years and over to community alcohol & drug services, who completed at least one face-to-face contact, during the audit period. (For women with more than one referral during the 3-month audit period, only enter 1st visit.)
Record review	• For randomly selected clients, record review to be conducted for the *index visit and up to two subsequent visits* if occurring within two months of the initial index visit. (For example, if client seen in April, review may extend through June; if client seen in June, review may extend through August).

Adult General Community Mental Health	
Service definition	• General adult community mental health services. This includes Kaupapa Māori, community, adult, non-residential mental health services. • Excluded are mental health residential services and mental health specialist services such as Community Adolescent Mental Health, Maternal Mental Health, Crisis Team and CAT (Crisis Assessment and Treatment).
Eligibility criteria	• All new women clients (seen for the first time by the service) and previous woman clients (who have been discharged from and re-referred to the service (as if they were a new client)), aged 16 years and over who presented to the adult general Community Mental Health Service and Kaupapa Māori Community Mental Health Services during the audit period.
Sampling	• If fewer than 25 new clients during the 3- month audit period, include them all in the audit.
Record review	• For randomly selected clients, record review to be conducted for the index visit and up to two subsequent visits if occurring within two months of the initial index visit. (For example, if client seen in April, review may extend through June; if client seen in June, review may extend through August).

4.3.4 CAN definitions

Eligibility criteria

Children aged under 2 years presenting to the **Emergency Department** for any reason during the audit period.

CAN Assessment

Was a child protection assessment done?	
NO:	• No evidence of a child protection checklist, screen or flowchart (i.e. no child injury checklist, child injury flowchart or equivalent in the notes, or documentation is present but is blank, or is partially completed).
YES:	• Evidence of a thorough child protection assessment (i.e. child protection checklist, child injury flowchart, or equivalent fully completed including legible signature).

CAN Concern

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

CAN Consultation

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

PDSA

Plan-Do-Study-Act

5.1 Overview

The VIP health systems approach includes supporting a culture of learning to increase the consistency and quality of our responsiveness to those impacted by family violence. The Model for Improvement provides a framework to guide us toward achieving service delivery improvements. The PDSA component provides the mechanism by which we are able to test small changes and build on these.

Current VIP service accountability measures include identification of persons experiencing IPV (routine enquiry) and CAN concerns (child protection checklist) followed by consultation and appropriate referral. DHBs are expected to use the MFI and PDSA cycles to make improvements in these core service delivery targets.

The PDSA method is a way to test whether or not a change has the positive outcome that is expected or not. By going through four steps it guides the thinking process into separate steps including evaluating the outcome and deciding whether to adopt, adapt or abandon the PDSA. We build our knowledge through multiple cycles in multiple conditions and move from a hunch that something will work to actually implementing the change, through multiple cycles. This cyclical process is one most of us use when implementing change in our lives, although we may not make it explicit. By writing down the steps (i.e. the PDSA cycle), it helps us to focus on the improvement process and learn more from it.

Keep the following in mind when using a PDSA cycle to implement change:

- Single focus:
    - Each PDSA often contains only a single step in an overall process, e.g. working on improved documentation of referrals as active or passive.
- Short duration:
    - Each PDSA cycle should be as brief as possible to gain knowledge on what is or is not working.
- Small sample size:
    - A PDSA will likely involve only a small segment of the service or practice such as one or two nurses. Once feedback is obtained, the process can be refined and implemented more widely.

5.2 PDSA due date

The 2019 PDSA due dates are:

- **04 October**: Submit two PDSA worksheets with only the PLAN required at this time.
- **09 December:** Submit the two PDSA worksheets with the PDSA cycle results (the PLAN and the DO, STUDY, ACT).

Please submit your worksheets by email to the evaluation team by sending to arlene.advani@aut.ac.nz.

5.3 Support and information

5.3.1. Online training

If you are unfamiliar with the Model for Improvement and PDSAs we strongly recommend the "**Improving Together**" online training course developed by Ko Awatea for the NZ Ministry of Social Development, Ministry of Education, Ministry of Health, Health Quality & Safety Commission NZ (2015).

This free training programme consists of four e-learning modules to provide you with an introduction to quality improvement and assistance in developing your PDSAs which takes approximately 2 hours to complete. At the end of the training you will receive a "Certificate of Completion"

The training can be accesses at: http://improvementmethodology.govt.nz/home

Click on 'Getting Started' to create an account and commence the training course.

5.3.2 PDSA on-line resources

- The IHI (Institute for Healthcare Improvement) website has a wealth of information to assist you complete a PDSA cycle.
- Further information and a Plan-Do-Study-Act workshop pack is available on the AUT Family Evaluation Project website also accessible through HIIRC VIP.

5.4 Completing your PDSA worksheets

The worksheets will have been sent to you with the 2019 evaluation information and there is also a copy at the back of this document.

5.4.1 Aim, objective and cycle number

- The aim should state what you are trying to accomplish (what problem are you solving)
- The objective is what you are trying to accomplish in the current cycle.
- The **cycle** number for this PDSA. As you work through a strategy of implementation you will often go back and adjust or tweak something and test to see if it is better or not. Each time you do this, it is new cycle.

5.4.2 PLAN (required by 04 October)

- The change we plan to test:
    - Write a concise statement of what you plan to do in this cycle of testing. It should be small and focused.
- The Question we want to answer for this cycle:
    - Phrase a question that links with your plan.
- Prediction:
    - Write the outcome that you predict will occur. You may have quantitative data like a certain number of nurses documented the referral in detail, or qualitative data such as nurses noticed they were more confident in asking about routine enquiry. For quantitative data, include the baseline measure and how much improvement you predict will occur.
- Data
- Detail what data is needed to test your predictions. Be specific. 'Tasks to complete'
    - Write the steps that you are going to take in this cycle. Include the following
        - Who – the population you are working with (e.g. patients or health professionals).
        - When – dates and times for when you will do the study and it only needs to be long enough to get some results. You may set a time limit of a week but notice after a day that it is not working. This cycle can be terminated and another one started.
        - Where – where will this be done (e.g. a specific ward).
        - How – how will you do it (e.g. ask the ward nurses at the end of the day three specific questions).

5.4.3 DO

After you have your plan, you will carry out your test. During the testing you will be keen to watch what happens once you do this.

- 'What problems or unexpected events did you observe?'
    - Write down your observations you have during the implementation – ask yourself
        - "'Did everything go as planned?"
        - "Did I have to modify the plan?"
- 'Feedback and observations from participants'
    - This may include how the patients react, how the health professionals react or how it fits in with your overall programme.

5.4.4 STUDY

After implementation you will study the results.

- 'What does the data show'
    - Write down what your saw in the data

- 'Was your prediction confirmed?'
    - Record if it met your goal, and how well it did or did not work
- 'Compare your data to predictions and summarise the learning'
    - What did you learn from this cycle about your programme.

5.4.5 ACT

- 'What did you conclude?'
    - Indicate whether you will adopt, adapt or abandon your change. If the test worked are you ready to roll it out for wider implementation?
    - If it did not work, what can you do differently in your next cycle to address that?

Model for Improvement (MFI) and PDSA Cycle **TIPS**

MFI and PDSA Cycle Refresher Notes

(S. Proudfoot, May2019)

1. Clearly communicate the 'problem' you are trying to solve and create a sense of urgency.
    a. local FV data re the scope of the problem is useful
    b. understand FV as a determinant of health
    c. aim is for quality health responsiveness to persons and family and whānau impacted by family violence; ensure that there is 'no wrong door' for people seeking help
2. Senior leadership must appreciate the problem and value the change (consider meeting with senior leaders, managers)
3. Create a sense of ownership by practitioners within services. Work on change WITH practitioners.
4. Important in PDSAs to be clear about what your prediction is (improve from X to Y) and test your prediction to see to see if what you thought would happen did. If not you may need to abandon or adapt. If it worked, try with a larger group.
5. Change happens one person at a time. Start small, with one person. How did it go? What were the barriers? What made it easy? Then test with 5, slowly increase.
6. We are wanting a massive change. Need to engage with an increasing number of people over time to grow commitment to change and decrease resistance to change (at least 10% of staff should be engaged with PDSAs leading up to implementing.
7. Need to continue to test as you move from one setting to the next.
8. For sustainability, needs to be owned by front line staff with local accountability and over-sight.

DHB:	
AIM	
Objective for this cycle:	
Cycle #:	
Planned start and end dates	
Actual end date:	

5.5 PDSA cycle worksheet

PLAN	
Briefly describe the change we plan to test:	
Questions: What question (s) do we want to answer on this PDSA Cycle?	
Prediction: What do we think will happen?	

Data: What data will we need to test our predictions (s)? How will we collect it?				
Tasks to be completed for the test	**Who**	**When**	**Where**	**How**

DO Carry out the change or test. Collect data and begin analysis	
What problems or unexpected events did we encounter?	

Feedback and observations from participants?	

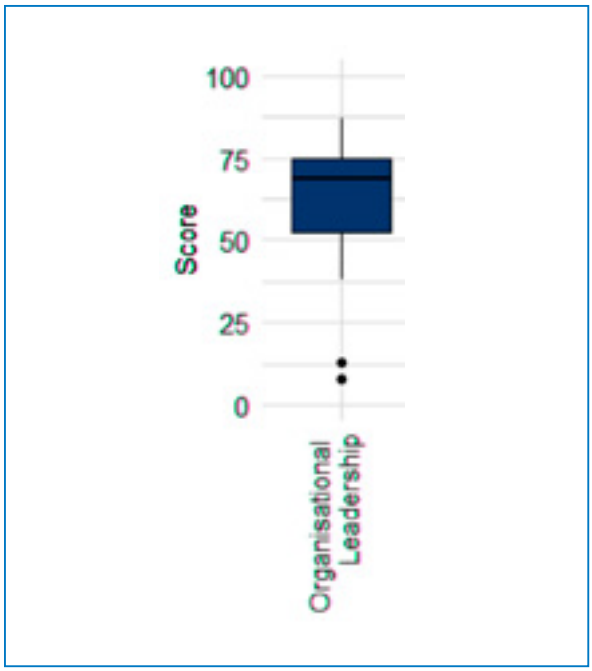
STUDY Complete analysis of data	
What does the data show?	
Was your predication confirmed? If not, what did you learn?	
Compare the data to your predictions and summarise the learning.	

ACT Following the test, we will (highlight one): **Adopt** or **Adapt** or **Abandon** the change	
What is you plan for the next cycle?	

References to assist you

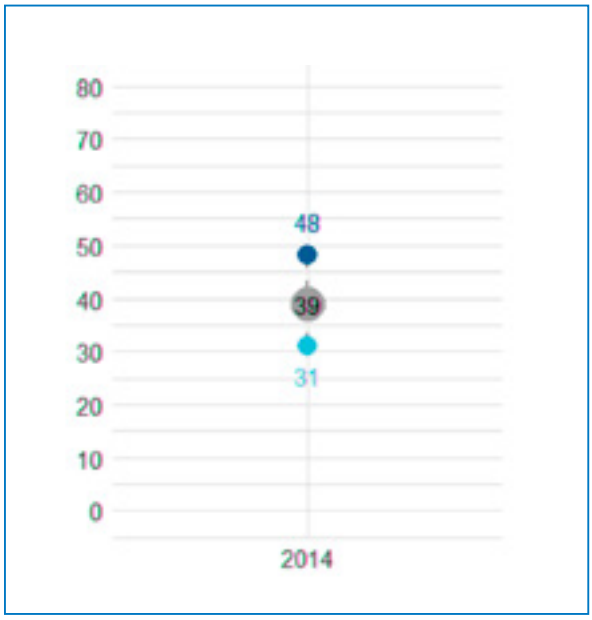
- Fanslow J L, Kelly P, Ministry of Health. 2016. Family Violence Assessment and Intervention Guideline: Child abuse and intimate partner violence (2nd edn). Wellington: Ministry of Health.
- Langley, G. J., Moen, R. D., Nolan, K. M., Nolan, T.W., Norman, C. L. & Provost, L. P. (2009). The improvement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

APPENDIX D: 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).
- The needles extending from the box indicate the score range, the highest and lowest scores that are not outliers (or extreme values).

APPENDIX E: HOW TO INTERPRET DUMBBELL PLOTS



- The y-axis represents the respective rate (enquiry, disclosure, referral for IPV; and assessment, concern, and consultation for CAN).
- The x-axis represents the year of this estimate.
- The grey circle in the centre indicates the weighted mean of the service's rate.
- The smaller green circles above and below of the weighted mean represent the 95% confidence interval for this estimate (light green for the lower CI and dark green for the upper CI).
- The dashed line represents the range of values that the weighted mean estimate can take (with 95% confidence).

APPENDIX F: DELPHI ITEM ANALYSIS

Note: Indicators met by ≥ 80% DHBs highlighted light blue.

Item	Domain: Organisational Leadership	Response (Yes)	
		2018	2019
1	There is a governance group with clearly defined roles and responsibilities for strategic leadership of the Violence Intervention Programme (VIP).	17 (85%)	19 (95%)
2	The following people with family violence understanding are active participants in the VIP governance group:		
2.1	At least one member of the DHB Executive Leadership Team (the most senior tier of DHB managers who report to the CEO or COO).	16 (80%)	19 (95%)
2.2	At least one professional leader of the core disciplines (e.g. Director of Nursing, Director of Midwifery, Chief Medical Officer, Director of Allied Health).	16 (80%)	19 (95%)
2.3	At least one directorate leader (or equivalent) from corporate services (e.g. Quality and Risk, Funding & Planning).	11 (55%)	14 (70%)
2.4	A Māori leader within the DHB or community.	15 (75%)	18 (90%)
2.5	Senior manager(s) responsible for services implementing VIP.	17 (85%)	20 (100%)
2.6	VIP team member (sponsor, manager or coordinator).	18 (90%)	20 (100%)
3	There is a two-way communication pathway between the governance group and the VIP team (includes VIP sponsor, VIP manager(s) and family violence intervention programme coordinator (FVIPC)).	16 (80%)	19 (95%)
4	Consistent with interagency Memorandum of Understanding (MOU), there are at least biannual meetings at the senior leadership level on family violence between the DHB with Police and Oranga Tamariki.	11 (55%)	14 (70%)
5	Executive leadership of VIP demonstrated by:		
5.1	District Annual Plan/Strategic Plan specifies VIP.	14 (70%)	16 (80%)
5.2	VIP status reporting to the DHB Board at least annually.	10 (50%)	12 (60%)

5.3	Quarterly agenda item for DHB Board or a designated Advisory Committee to the Board regarding VIP contract deliverables and KPIs.	7 (35%)	11 (55%)
5.4	Current, endorsed DHB policy that includes compulsory 8-hour VIP core training for *all* clinical staff in designated services.	20 (100%)	20 (100%)
5.5	Implementing and monitoring the key performance indicators (KPIs) *reporting* by services.	10 (50%)	11 (55%)
5.6	Evidence of acting on non-attained KPI(s), noting recommendations for improvement, necessary resourcing and follow up.	8 (40%)	9 (45%)
6	Senior clinical leaders communicate the expected VIP standard of clinical practice to their professional group(s)		
6.1	Clinical Director (Chief Medical Officer)	8 (40%)	7 (35%)
6.2	Director of Nursing	8 (40%)	11 (55%)
6.3	Director of Midwifery	13 (65%)	13 (65%)
6.4	Director of Allied Health	11 (55%)	12 (60%)
7	Service Leaders report on the following key performance indicators (KPIs) to their senior managers at least quarterly.		
7a	Please indicate how many of the six designated services the DHB provides.		
7.1	How many of the services report on the proportion of staff trained in VIP? (Average)	2.3	1.71
7.2	How many of the services report on the number of VIP clinical champions? (Average)	2.45	1.71
7.3	How many of the services report on assessment and intervention compliance with policy? (Average)	1.25	1.43
7.4	How many of the services report on actions taken to address any non-compliance? (Average)	1.3	1.24
8	The implications of DHB initiatives on VIP service delivery where relevant are considered (e.g. design, documentation forms, alert systems).	16 (80%)	15 (75%)
9	At least 80% of senior executives/leadership team members (including the VIP sponsor) and senior service level managers have received training in VIP in the past two years.	0 (0%)	0 (0%)

Item	Domain: Training and Support	Response (Yes)	
		2018	2019
1	The DHB VIP core training package and any updates have been signed off by the national training provider.	20 (100%)	19 (95%)
2	The DHB training programme has been observed by the national training provider in the past two years with a report sent back with feedback and recommendations.	14 (70%)	16 (80%)
3	There are positive reinforcement practices in place (e.g. inclusion in staff review process) to encourage staff in designated services to conduct routine enquiry for family violence.	18 (90%)	19 (95%)
4	Follow-up support occurs within one week of training.	12 (60%)	13 (65%)
5	Information about the VIP (including DHB policy) is provided at the orientation for service staff appointed to the DHB.	16 (80%)	17 (85%)
6	The family violence training programme includes dealing with difference, i.e. bicultural (as informed by Māori Health Unit), multicultural, disability, gender identity and sexual orientation.	19 (95%)	19 (95%)
7	Staff are evaluated/surveyed on their knowledge and attitude to family violence and its impact on Māori.	15 (75%)	16 (80%)
8	There are support services available for DHB staff who have experienced/are experiencing family violence (including perpetrator and victim)	19 (95%)	20 (100%)

Item	Domain: Resource Funding	Response (Yes)	
		2018	2019
1	The DHB funding and any extra funding for VIP is spent on the programme and not diverted elsewhere.	20 (100%)	20 (100%)
1.1	There is extra funding provided for people and resources specifically to reduce the impact of family violence on Māori.	7 (35%)	11 (55%)
1.2	There is allocated administrative resources and support for the VIP.	15 (75%)	15 (75%)
2	The family violence intervention programme coordinator (FVIPC) roles for IPV and CAN are currently filled.	18 (90%)	18 (90%)
2.1	How many months in the past 12 months has the coordinator role been filled? Please enter a number between 0 and 12.	0.95	0.95

Item	Domain: VIP Practices	Response (Yes)	
		2018	2019
1	At least 80% of women receive routine inquiry for IPV in each designated service.	1 (5%)	0 (0%)
2	At least 5% of women who receive a routine inquiry disclose IPV in each designated service	4 (20%)	4 (20%)
3	All women who disclose IPV are offered a referral to a specialised service or agency.	14 (70%)	15 (75%)
4	A Child Protection Checklist is completed for at least 95% children under the age of two presenting in an Emergency Department.	3 (15%)	3 (15%)
5	There is evidence of consultation with someone who has child protection specialist knowledge for all cases when child protection concerns are identified.	14 (70%)	15 (75%)
6	For all Reports of Concern (ROC) made to Oranga Tamariki, child protection concerns are identified, and safety plans are documented.	12 (60%)	13 (65%)
7	Assessments of the safety of children in the care of all persons disclosing IPV occurs, evident in the most recent quarterly chart audit or electronic record report.	12 (60%)	14 (70%)

Item	Domain: Cultural Responsiveness	Response (Yes)	
		2018	2019
1	Knowledge of family violence dynamics that address personal and whānau needs for specific groups are embedded in the VIP policy:		
1.1	Māori	20 (100%)	20 (100%)
1.2	Other cultures	20 (100%)	20 (100%)
1.3	Disabled	16 (80%)	17 (85%)
1.4	Gender identity	17 (85%)	18 (90%)
2	The DHB ensures delivery of a culturally competent VIP service, and cultural competency of its staff, particularly for Māori. Please list some ways that this is evident.		
2.1	Cultural competency of the service is evident in VIP policy.	19 (95%)	19 (95%)
2.2	Cultural competency is included in VIP training.	19 (95%)	19 (95%)
2.3	Cultural competency of staff is assessed through staff surveys of attitudes and understanding or family violence and its impact for Māori.	11 (55%)	12 (60%)
2.4	Feedback is sought from Māori who interact with the VIP service that specifically addresses the cultural responsiveness of the service.	6 (30%)	8 (40%)
3	A whānau-centred response is followed when working with victims of family violence. "Māori and their whānau remain the central focus of health professionals' activities, involving them in planning and decision-making activities and when deciding which services are needed to achieve their goals. Identifies both the collective and individual whānau members." (Wepa, 2015, p.242)	10 (50%)	13 (65%)
	Please provide examples to support rating:		

4	There are culturally inclusive family violence pathways and services available in the community.	20 (100%)	19 (95%)
	Provide examples:		
5	The delivery of the service for Māori is evaluated by Māori in a way that is culturally appropriate and safe. *(Yes, Māori-led)*	1 (5%)	4 (20%)
6	Trained and approved health care interpreters with family violence training are available for translating for individuals and family if English is not their first language.	16 (80%)	15 (75%)
7	Information is available, relevant, and on display in Te Reo.	16 (80%)	16 (80%)
7.1	Information is available or on display in other languages (not including English) that reflects the DHB's catchment demographic if needed. List the languages that should be available (i.e. reflect demographic):	12 (60%)	15 (75%)
	List languages:		

Item	**Domain: Quality Improvement**	**Response (Yes)**	
		2018	**2019**
1	VIP is included in the DHB quality and risk strategic plan.	6 (30%)	8 (40%)
2	There is a formal VIP quality improvement plan.	11 (55%)	13 (65%)
3	Responsibility for acting on quality improvement findings is clearly outlined in VIP policy and formal strategic (family violence and child protection) quality improvement process plan.	10 (50%)	12 (60%)
4	There is a regular formal process whereby the VIP evaluation and quality improvement findings are discussed, reviewed and acted on with respective services.	12 (60%)	14 (70%)
5	Evaluation includes health care providers receiving feedback relevant to their involvement with the VIP.	18 (90%)	18 (90%)
6	Patient/client or community agency feedback regarding VIP service delivery is gathered and analysed on a regular basis (at least annually).	7 (35%)	10 (50%)
7	Staff in designated services where VIP is implemented are asked to provide feedback including ideas for programme enhancement in their services every two years.	14 (70%)	16 (80%)
8	A Māori quality framework (such as Whānau Ora) is used by DHB leadership to evaluate whether services are effective for Māori.	6 (30%)	10 (50%)
8.1	This process includes Māori Health Unit review of feedback and recommendations for improving the VIP effectiveness for Māori.	6 (30%)	9 (45%)
8.2	Please provide examples of how the service's effectiveness for Māori is evaluated?		
9	There is evidence that changes have been made to the VIP on the basis of staff, community or user feedback, or audit findings, in the past 12 months.	19 (95%)	20 (100%)
9.1	If no changes please explain why (e.g. feedback positive, no budget). If changes, please summarise what the feedback was, how it was sourced and what the changes were.		

Item	Domain: Policies and Procedures	Response (Yes)	
		2018	2019
1	The DHB has documented policies and procedures on intimate partner violence and child protection that are current and align with the Ministry of Health guideline	20 (100%)	20 (100%)
2	The DHB family violence policies and procedures are aligned with current legislation and relevant national policy initiatives (e.g. MOUs)	20 (100%)	19 (95%)
3	The policies and procedures are readily available to staff on the intranet (within 3 clicks).	19 (95%)	20 (100%)
4	The Māori Health Unit participate in policy review and endorse all DHB family violence policy and procedure.	16 (80%)	15 (75%)
5	Additional safety and security measures are specified for suspected cases of child abuse and neglect with perceived immediate risk, and for adults who are identified as high risk or in imminent threat.	20 (100%)	20 (100%)

Item	Domain: Collaboration	Response (Yes)	
		2018	2019
1	There is clear evidence that a Memorandum of Understanding (MOU) between the DHB and Oranga Tamariki and Police for family violence responses has been operationalised by:		
1.1	Signing of MOU	20 (100%)	20 (100%)
1.2	Regular meetings at service level with actions and accountability (at least biannual)	12 (60%)	13 (65%)
1.3	Interagency review of cases	14 (70%)	14 (70%)
1.4	Participation in or initiation of interagency training	15 (75%)	18 (90%)
2	There is evidence of Service Level Agreements (SLA) between DHB and family violence services with regards to referrals and how on-site services will be provided.	12 (60%)	16 (80%)
3	Ongoing partnership between the DHB and Māori service agencies or health providers, and/or local Iwi or Urban Māori Authority evidenced by:		
3.1	Participation in, or initiation, of training (e.g. involvement in the VIP training at the DHB)	10 (50%)	10 (50%)
3.2	Policy review	8 (40%)	11 (55%)
3.3	Representation on the VIP governance group	9 (45%)	9 (45%)
4	There is evidence of engagement and collaboration with external family violence services agencies at a senior management and operational VIP level		
4.1	Senior management level (provide examples)	17 (85%)	19 (95%)
4.2	Operational VIP level (provide examples)	18 (90%)	19 (95%)
5	There is an MOU or SLA with the following agencies regarding the service delivery for victims of sexual assault (adults, adolescents and children).		
5.1	Police	18 (90%)	19 (95%)
5.2	ACC	16 (80%)	17 (85%)

5.3	Oranga Tamariki	15 (75%)	17 (85%)
5.4	DHB policies specify the pathway for service delivery including acute response and referral for sexual assault or suspected/alleged sexual abuse of a child.	18 (90%)	19 (95%)
6	At least two multiagency case reviews (one for IPV and one for CAN) have been undertaken in the last 12 months that evaluate health actions within family violence response.		11 (55%)
6.1	At least 1 review for IPV?	11 (55%)	14 (70%)
6.2	At least 1 review for CAN?	15 (75%)	20 (100%)
6.3	How have findings been shared with DHB services?		
6.4	How have recommendations been actioned?		

Item	**Domain: Documentation**	**Response (Yes)**	
		2018	**2019**
1	Standardised documentation instruments (or templates) that are aligned with the Ministry of Health FVAIG are used to record known or suspected cases of family violence.	19 (95%)	20 (100%)
1.1	All IPV routine enquiry, disclosures and referrals are documented on the standardised templates (e.g. Intimate Partner Violence (IPV) Assessment and Intervention Documentation)	18 (90%)	18 (90%)
2	The national form (Report of Concern) is used for referral to Oranga Tamariki	20 (100%)	20 (100%)
3	Patients with injuries caused by family violence are routinely offered a medical photography option, either in the DHB or by the police.	16 (80%)	18 (90%)

APPENDIX G: EMERGENCY DEPARTMENT POPULATION ESTIMATES OF CHILDREN UNDER TWO YEARS OF AGE WHO RECEIVED CHILD ABUSE AND NEGLECT (CAN) ASSESSMENT AND SERVICE (APRIL – JUNE; 2014 -2019)

	Children assessed for CAN indicators						Protection concern (≥ 1 indicator)						Specialist consultation					
	2014	2015	2016	2017	2018	2019	2014	2015	2016	2017	2018	2019	2014	2015	2016	2017	2018	2019
Weighted mean	27%	26%	26%	39%	48%	55%	13%	9%	12%	10%	9%	5%	89%	100%	93%	100%	96%	90%
95% CI	20%, 34%	21%, 32%	21%, 32%	33%, 45%	41%, 54%	46%, 65%	8%, 18%	6%, 12%	8%, 15%	7%, 13%	7%, 11%	4%, 7%	*	*	*	*	*	*
Population estimate	4163	4242	3404	6197	7953	9,308	549	374	394	601	742	495	489	374	380	601	690	429
95% CI					6845, 9061	7,713, 10,902					582, 901	2,124, 3,139	*	*	*	*	*	*

Notes: proportion of child protection concern is among those who received an CAN assessment; proportion of specialist consultation is among those with an identified concern; CI = Confidence Intervals; CI not computed for consultations due to small numbers within individual DHBs.

APPENDIX H: IPV SERVICE POPULATION ESTIMATES

Population estimates of intimate partner violence assessment, disclosure and referral rates by service (April – June 2014 - 2019).

	Assessment						Disclosure						Referral					
	2014	2015	2016	2017	2018	2019	2014	2015	2016	2017	2018	2019	2014	2015	2016	2017	2018	2019
Post-natal Maternity In-Patient																		
Weighted mean (95% CI)	33% (26, 39)	48% (42, 55)	52% (46, 58)	53% (49, 57)	62% (57, 68)	53% (48, 59)	9% (3, 14)	4% (2, 6)	3% (2, 4)	4% (3, 6)	3% (1, 4)	8% (6, 10)	75% *	100% *	83% *	60% *	82% *	78% *
Population estimate (95% CI)	2935	4637 (,033, 5241	4954 (4374, 5533)	5965 (5484, 6446)	7531 (6870, 8193)	7154 (6450, 7858)	257	197 (114, 280)	138 (79, 197)	264 (156, 373)	191 (109, 272)	580 (422, 737)	193 *	197 *	125 *	232 *	169 *	516 *

	Assessment						Disclosure						Referral					
	2014	2015	2016	2017	2018	2019	2014	2015	2016	2017	2018	2019	2014	2015	2016	2017	2018	2019
Child Health In-Patient																		
Weighted mean (95% CI)	39% (31, 48)	35% (33, 38)	42% (36, 48)	39% (36, 43)	43% (39, 48)	44% (38, 49)	6% (4, 9)	4% (2, 5)	4% (2, 5)	7% (5, 9)	11% (7,15)	11% (7, 14)	70% *	100% *	75% *	69% *	72% *	90% *
Population estimate (95% CI)	4869	4213 (4180, 4847)	5180 (4423, 5937)	5118 (4640, 5595)	4655 (4163, 5146)	4,864 (7,208, 5,520)	259	160 (83, 237)	193 (116, 271)	339 (237, 441)	505 (327, 683)	513 (363, 662)	181 *	160 *	125 *	255 *	366 *	492 *

	Assessment						Disclosure						Referral					
	2014	2015	2016	2017	2018	2019	2014	2015	2016	2017	2018	2019	2014	2015	2016	2017	2018	2019
Sexual Health																		
Weighted mean (95% CI)	N/A	48% (42, 55)	54% (44, 63)	67% (56, 79)	69% (53, 85)	75% (68, 82)	N/A	20% (13, 27)	15% (11, 19)	19% (11, 26)	10% (7, 13)	16% (12, 19)	N/A	83% *	69% *	55% *	58% *	63%
Population estimate (95% CI)	N/A	2703 (2330, 3076)	3917 (3243, 4591)	4643 (3835, 5450)	5298 (4076, 6520)	4,543 (3,377, 4,105)	N/A	537 (349, 725)	589 (437, 742)	860 (500, 1220)	530 (366, 693)	713 (554, 873)	N/A	466 *	388 *	627 *	425 *	437 *

	Assessment						Disclosure						Referral					
	2014	2015	2016	2017	2018	2019	2014	2015	2016	2017	2018	2019	2014	2015	2016	2017	2018	2019
Emergency Department																		
Weighted mean (95% CI)	N/A	23% (20, 26)	27% (24, 29)	30% (26, 34)	32% (27, 37)	28% (24, 31)	N/A	6% (4, 8)	14% (11, 18)	12% (9, 15)	22% (14, 31)	7% (5, 9)	N/A	75% *	94% *	78% *	88% *	80%
Population estimate (95% CI)	N/A	21,924 (18,819; 25,029)	25,758 (22,887; 28,628)	30,330 (26,418; 34,243)	34,314 (28,665; 39,963)	32,899 (28,947, 36,852)	N/A	1310 (917, 1702)	3568 (2806, 4510)	3544 (2639, 4448)	7677 (4736, 10617)	2,300 (1,489, 3,111)	N/A	982 *	3581 *	2418 *	7031 *	1754 *

	Assessment						Disclosure						Referral					
	2014	2015	2016	2017	2018	2019	2014	2015	2016	2017	2018	2019	2014	2015	2016	2017	2018	2019
Alcohol & Drug[a]																		
Weighted mean (95% CI)	N/A	N/A	52% (38, 67)	61% (47, 76)	53% (43, 62)	56% (43, 69)	N/A	N/A	34% (25, 44)	27% (19, 35)	30 (23, 37)	25% (20, 30)	N/A	N/A	59% *	88% *	87% *	78%
Population estimate (95% CI)	N/A	N/A	829 (602, 1055)	894 (688, 1100)	1358 (1110, 1606)	993 (759, 1,226)	N/A	N/A	285 (205, 365)	239 (168, 311)	410 (316, 504)	248 (194, 302)	N/A	N/A *	152 *	175 *	350 *	210 *

	Assessment						Disclosure						Referral					
	2014	2015	2016	2017	2018	2019	2014	2015	2016	2017	2018	2019	2014	2015	2016	2017	2018	2019
Community Mental Health[a]																		
Weighted mean (95% CI)	N/A	N/A	52% (43, 62)	40% (32, 48)	44% (36, 51)	49% (42, 56)	N/A	N/A	24% (19, 29)	28% (22, 34)	20% (17, 23)	29% (23, 36)	N/A	N/A	64% *	90% *	82% *	77%
Population estimate (95% CI)	N/A	N/A	1769 (1444, 2095)	2369 (1977, 2987)	2878 (2366, 3391)	3,172 (2,720, 3,624)	N/A	N/A	422 (336, 511)	661 (538, 839)	576 (483, 669)	933 (726, 1,141)	N/A	N/A	257 *	597 *	394 *	693 *

Notes: [a] New female clients presenting to service; CI not computed for referrals due to small numbers within individual DHBs.

APPENDIX I: SERVICE DELIVERY RATES BY MĀORI, NON-MĀORI

Note: (percent, 95% CI)

Child abuse & neglect service delivery rates for children under two years presenting to the emergency department (April – June; 2014-2019)

	2014		2015		2016		2017		2018		2019	
	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori
Eligible Sample	391	175	392	183	400	150	379	168	348	154	366	175
Assessment	72 (18%, 15/23)	50 (29%, 22/36)	107 (27%, 23/32)	45 (25%, 19/31)	103 (26%, 22/30)	24 (16%, 11/23)	139 (37%, 32/42)	54 (32%, 26/40)	166 (48%, 43/53)	58 (38%, 30/46)	183 (50%, 45/55)	75 (43%, 36/50)
Concern	5 (7%, 3/15)	13 (26%, 16/40)	6 (6%, 3/12)	10 (22%, 13/36)	7(7%, 3/13)	8 (33%, 18/53)	8 (6%, 3/11)	6 (11%, 5/22)	12 (7%, 4/12)	11 (19%, 11/31)	11 (6%, 3/10)	9 (12%, 6/21)
Specialist Consultation	3	13	6	10	7	7	8	5	11	11	11	7

Intimate partner violence service delivery rates

Postnatal maternity

	2014		2015		2016		2017		2018		2019	
	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori
Eligible Sample	429	120	439	137	437	120	438	110	416	111	401	131
Assessment	160 (37%, 33/42)	53 (44%, 36/53)	229 (52%, 47/57)	60 (44%, 36/52)	239 (55%, 50/59)	67 (56%, 47/64)	247 (56%, 52/61)	55 (50%, 41/59)	257 (62%, 57/66)	68 (61%, 52/70)	225 (56%, 51/61)	65 (50%, 41/58)
Disclosure	9 (6%, 3/10)	7 (13%, 7/25)	7 (3%, 1/6)	7 (12%, 6/22)	7 (3%, 1/6)	5 (7%, 3/16)	4 (2%, 1/4)	6 (11%, 5/22)	6 (2%, 1/5)	5 (7%, 3/16)	13 (6%, 3/10)	5 (8%, 3/17)
Specialist Consultation	7	5	7	7	5	5	2	4	6	3	13	3

Child Health In-patient

	2014		2015		2016		2017		2018		2019	
	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori
Eligible Sample	740	340	381	169	396	155	398	153	356	145	364	166
Assessment	269 (36%, 33/40)	107 (31%, 27/37)	149 (39%, 34/44)	73 (43%, 36/51)	172 (43%, 39/48)	59 (38%, 31/46)	167 (42%, 37/47)	61 (40%, 32/48)	160 (45%, 40/50)	80 (55%, 47/63)	153 (42%, 37/47)	82 (49%, 42/57)
Disclosure	11 (4%, 2/7)	12 (11%, 7/19)	4 (3%, 1/7)	5 (7%, 3/15)	4 (2%, 1/6)	4 (7%, 3/16)	11 (7%, 4/11)	5 (8%, 4/18)	12 (8%, 4/13)	6 (8%, 3/15)	11 (7%, 4/12)	9 (11%, 6/20)
Specialist Consultation	4	4	4	5	4	2	7	4	11	5	11	9

Emergency Department

	2015		2016		2017		2018		2019	
	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori
Eligible Sample	447	104	440	111	460	113	383	117	423	112
Assessment	119 (27%, 23/31)	26 (25%, 18/34)	121 (28%, 24/32)	29 (26%, 19/35)	151 (33%, 29/37)	37 (33%, 25/42)	108 (28%, 24/33)	41 (35%, 27/44)	126 (30%, 26/34)	34 (30%, 23/39)
Disclosure	4 (3%, 1/8)	4 (15%, 6/34)	13 (11%, 6/18)	5 (17%, 8/35)	16 (11%, 7/17)	2 (5%, 1/18)	17 (16%, 10/24)	8 (20%, 10/34)	8 (6%, 3/12)	2 (6%, 2/19)
Specialist Consultation	2	4	12	5	12	2	15	7	8	2

Sexual Health

	2015		2016		2017		2018		2019	
	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori
Eligible Sample	277	101	290	101	275	89	272	96	270	110
Assessment	165 (60%, 54/65)	69 (68%, 59/77)	197 (68%, 62/73)	59 (58%, 49/68)	202 (73%, 68/78)	60 (67%, 57/76)	207 (76%, 71/81)	75 (78%, 69/85)	208 (77%, 72/82)	85 (77%, 69/84)
Disclosure	28 (17%, 12/23)	6 (9%, 4/18)	20 (10%, 7/15)	10 (17%, 9/28)	29 (14%, 10/20)	11 (18%, 11/30)	22 (11%, 7/16)	14 (19%, 11/29)	31 (15%, 11/20)	18 (21%, 14/31)
Specialist Consultation	24	4	14	8	15	7	15	6	31	18

Alcohol & Drug

	2016		2017		2018		2019	
	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori
Eligible Sample	242	120	258	81	235	115	248	108
Assessment	124 (51%, 45/57)	49 (41%, 32/50)	143 (55%, 49/61)	52 (64%, 53/74)	155 (66%, 60/72)	65 (57%, 47/65)	160 (65%, 58/70)	62 (57%, 48/66)
Disclosure	33 (27%, 20/35)	18 (37%, 25/51)	37 (26%, 19/34)	16 (31%, 20/44)	46 (30%, 23/37)	21 (32%, 22/44)	51 (32%, 25/39)	17 (27%, 18/40)
Specialist Consultation	19	11	35	14	42	16	51	14

Community Mental Health

	2016		2017		2018		2019	
	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori
Eligible Sample	380	107	366	128	396	99	392	106
Assessment	182 (48%, 43/53)	46 (43%, 34/52)	171 (47%, 42/52)	51 (40%, 32/49)	214 (54%, 49/59)	32 (32%, 24/42)	229 (58%, 53/63)	57 (54%, 44/63)
Disclosure	33 (18%, 13/24)	9 (20%, 11/33)	45 (26%, 20/33)	15 (29%, 19/43)	41 (19%, 14/25)	14 (44%, 28/61)	58 (25%, 20/31)	24 (42%, 30/55)
Specialist Consultation	23	4	41	14	39	13	58	22

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VIP violence intervention programme

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