HEALTH RESPONSE TO FAMILY VIOLENCE:

2018 VIOLENCE INTERVENTION PROGRAMME EVALUATION

CENTRE FOR INTERDISCIPLINARY TRAUMA RESEARCH
AUT UNIVERSITY

MINISTRY OF HEALTH
MANATŪ HAUORA

VIP violence intervention programme

AUT

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2018 VIOLENCE INTERVENTION PROGRAMM EVALUATION

Jane Koziol-McLain, PhD, RN
Professor of Nursing

Moira Howson, M.HSc
Centre for Interdisciplinary Trauma Research

Brice Valentin Shun, M.Analytics (Hons)
Department of Biostatistics and Epidemiology

Nick Garrett, PhD
Department of Biostatistics and Epidemiology

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

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

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

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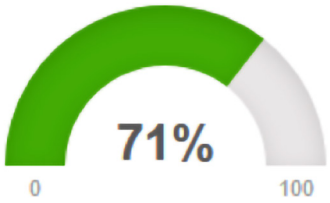
CONTENT

VIP EVALUATION 2017-2018

The VIP evaluation project monitors how District Health Boards (DHBs) are responding to Ministry of Health (MOH) initiatives aimed at increasing the responsiveness of the health system to the needs of women, children and whānau at risk for family violence.

Median Delphi Score



DELPHI INFRASTRUCTURE SCORE

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.

The average infrastructure score was **71** and **20%** of DHBs scored higher than **83**.

DELPHI INFRASTRUCTURE DOMAINS

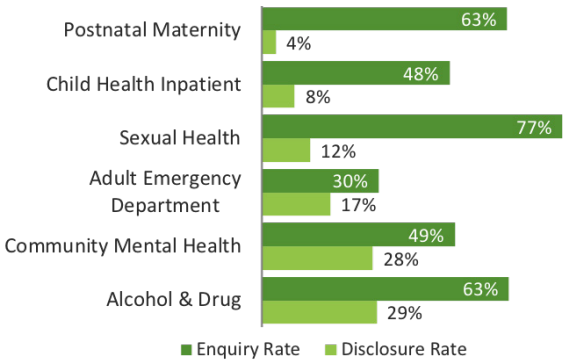
HIGH PERFORMANCE
- Documentation
- Policies & Procedures

MEDIUM PERFORMANCE
- Organisational Leadership
- Training & Support
- Resource Funding
- Cultural Responsiveness
- Collaboration

LOW PERFORMANCE
- Quality Improvement
- VIP Practices

CLINICAL AUDITS SNAPSHOT (APRIL-JUNE 2018)

Intimate Partner Violence



DHB Service Locations Achieving Target Rates

18/110 (16%)
INTIMATE PARTNER VIOLENCE

2/20 (10%)
CHILD ABUSE & NEGLECT

Intimate Partner Violence (IPV)
Target Rates 80% enquiry; 5% disclosure

Child Abuse and Neglect (CAN)
Target Rates 80% assessment; 5% concern

National Estimates of CAN Services (April-June 2018)

7953
Assessment

7953
Concern

690
Consultation

Child Protection Services (April-June 2018)

48% of ED visits by **children under two** included a brief child protection assessment. Among children assessed, a **child protection concern** was noted in **9%**. With a concern, a **specialist consultation** occurred **96%** of the time

48%
ASSESSMENT RATE

9%
CONCERN RATE

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 2017 to 30 June 2018. 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]

VIP Infrastructure Audits

Scaling up a quality, sustainable health response to family violence is reliant on quality systems.[4–10] In 2017, VIP system indicators were refreshed during three Delphi rounds involving a panel of experts. System indicators for IPV and CAN have been prioritised and included in a single Delphi tool (replacing earlier IPV and CAN tools). The revised tool includes 9 domains; standardised scores may range from 0 to 100. DHBs scored themselves on each of the 56 items.

- Across the 20 DHBs, the overall Delphi score ranged from 43 to 91. The typical (median) score was 71. Twenty percent of DHBs scored 83 or higher.
- High scores were evident across DHBs in the *Policies & Procedures* (median=100) and *Documentation* (median=100) domains. This is attributed to the significant effort by DHB and national VIP staff during the evaluation period to update policies, procedures and standardised documentation to align with the revised 2016 *Family Violence Assessment and Intervention Guideline: Child Abuse and Intimate Partner Violence*.[2]
- The *Quality Improvement* (median=50) and *VIP Practices* (median = 57) domain scores indicate areas for further infrastructure support and development. Additional detail is provided in Chapter 3.

VIP 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[11] in the delivery of services for vulnerable children and their whānau or families. Snapshot audits allow pooling of DHB data to estimate (a) VIP output – women and children assessed for violence and abuse – as well as (b) VIP outcomes – women and children with a violence concern who received specialist assistance.

DHB Snapshot audits involve annual retrospective reviews of a random selection of 25 clinical records from the three-month period 1 April to 30 June for each of the targeted services. Snapshot clinical audit benchmarks for 2018 included: IPV and CAN assessment rates ≥ 80% and IPV disclosure and CAN concern rates ≥ 5%.

Child Protection Service Delivery

Assessment. Among emergency department visits by children under two years of age during the three-month audit period (April – June) in 2018:

- **48% were assessed for child abuse and neglect.**
- Nationwide, we estimate that nearly eight thousand (7953) children received a child protection assessment during the three-month 2018 audit period.

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

- **A child protection concern was noted for 9%.**
- Nationwide, we estimate a concern about safety was identified in over 700 (742) children during the three-month 2018 audit period.

Specialist Consultation. Among children under two years of age who presented to an emergency department during the three-month audit period and were assessed for child abuse and neglect and had a child protection concern identified:

- **96% received a specialist consultation.** This rate has varied between 89% (2014) and 100% (2015 and 2017).
- Nationwide, we estimate that 690 children received specialist consultation for a child protection concern during the three-month 2018 audit period.

Despite a small variation in the rate of identifying a child protection concern over a five year period (between 9% and 13%), the increasing rate of assessment meant that many more children presenting to the emergency department were assessed and their cases reviewed with a senior specialist.

Intimate Partner Violence Service Delivery

Assessment. During the three-month audit period (April–June 2018):

- The proportion of eligible women's visits that included an IPV assessment ranged from 32% in the emergency department to 69% in sexual health.

Disclosure. During the three-month audit period (April–June 2018), among visits by women assessed for IPV:

- The proportion of visits in which women disclosed IPV ranged from 3% in postnatal maternity to 30% in alcohol and drug services.
- Nationwide, during the three-month audit period, we estimate that nearly ten thousand (9889) visits by women included an IPV disclosure to a health worker across the six targeted services.
- Due to the consistently higher disclosures in some services over time, the IPV disclosure benchmark has been increased for 2019 (see detail in Chapter 4).

Referrals. During the three-month audit period (April–June 2018), in visits among women who disclosed IPV:

- The proportion who received a specialist referral ranged from 58% in sexual health to 95% in community mental health.
- Nationwide, we estimate that nearly nine thousand (8676) visits by women who disclosed IPV to their health worker included a specialist referral.

Our national estimates indicate that most women who received specialist family violence services in 2018 during the three-month audit period were referred through the emergency department (n=7,031), followed by sexual health (n=425) or community mental health (n=394). These services have IPV disclosure rates greater than 5%; and, in the case of emergency department service, high patient volumes.

Average assessment and disclosure rates mask variability in service delivery. In 2018, there were 18 service locations that achieved IPV assessment rates ≥ 80% and disclosures rates ≥ 5% (within the target zone). These 18 services were located in 9 DHBs and reflect an achievement rate of 16% (based on 110 VIP service locations assessed in the Snapshot audit; 20 DHBs X 6 services less 10 contracted out services). This was an increase from 10% (11 service locations in 2017). Two of twenty DHBs achieved target CAN assessment and concern rates.

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. Forty PDSA cycle plans were submitted, 29 of which were completed. Among those completed, 21 documented either an increased understanding of their system or a performance increase following implementing their planned change action. Examples of successful change actions included partnering with unit management and champions to improve IPV routine enquiry; providing daily or weekly feedback to staff to improve IPV routine enquiry or child protection assessment; and chart reminders (large dots) to improve child protection assessments in the emergency department. Several DHBs tested offering post-training support, but found it resource intensive, and thus difficult to implement. While some 'nudges' were effective, new forms, digitalised forms, and training by itself rarely resulted in measured improvements.

Summary

VIP 2017–2018 evaluation data indicate that while VIP is being successfully implemented in a small number of service locations in selected DHBs, further improvements are needed to deliver a consistent, quality service nationwide to vulnerable children, women and whānau or families living with violence. This quantitative assessment of system development and clinical practice provides a wealth of information to inform feedback loops fostering learning and critical analysis of change.

INTRODUCTION

Internationally and within New Zealand, family violence is acknowledged as a preventable public health problem and human rights violation that impacts significantly on women, children, whānau and communities.[8,13–16] Early identification of people subjected to violence followed by a supportive and effective response can improve safety and wellbeing.[8] The health care system is an important point of entry for the multi-sectoral response to family violence, including both preventing violence and treating its consequences.

The Ministry of Health ('the Ministry') began the Family Violence Health Intervention Project in 2001 (see Appendix A) and launched the renamed Violence Intervention Programme (VIP) in 2007. VIP seeks to reduce and prevent the health impacts of violence and abuse through early identification, assessment and referral of victims presenting to health services. This programme provides the infrastructure for the health sector response, which is one component of the multi-agency approach to reduce family violence in New Zealand. The Violence Intervention Programme has been strategically aligned with the Ministry's Statement of Intent 2014 to 2018.[17] The Ministry of Health's VIP programme is ideally placed to respond to new legislation and future family violence and sexual violence cross-government joint venture work programme initiatives.[18]

VIP is premised on a standardised, comprehensive systems approach[8–10,19] supported by six programme components funded by the Ministry (Figure 1). These components include:

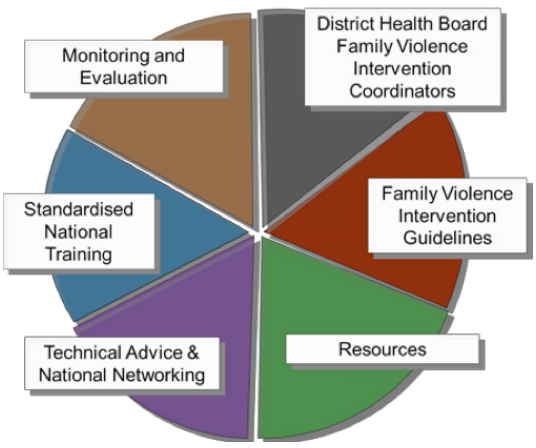


Figure 1. Ministry of Health VIP Systems Support Model (DHBs)

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

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.[20–22] The quantitative Delphi scores provide a means of monitoring infrastructure across the 20 DHBs over time. This work stream has led to important national initiatives directing programme funding, development of the VIP Quality Improvement Toolkit, Model for Improvement workshops and a Whānau-Centred resource.[23] **Secondly**, programme service delivery is measured by VIP Snapshot clinical audits. Snapshot audits conducted in New South Wales have proved useful in monitoring service delivery.[24] Snapshot clinical audits measure women and children assessed for violence and abuse and women and children with a violence concern who receive specialist assistance. The Snapshots provide accountability data and the inaugural audits in 2014 serve as baseline for monitoring the effect of system changes. **Thirdly**, Model for Improvement Plan-Do-Study-Act (PDSAs)[12] worksheets are part of the evaluation process as a quality improvement initiative. DHBs complete two PDSAs focused on improving DHB IPV routine enquiry and disclosure rates or CAN child protection assessment and concern rates.

This evaluation report provides practice-based evidence of the current violence intervention programme inputs, outputs and outcomes (Figure 2). Together, the Delphi infrastructure, programme information and Snapshot audits deliver data to the Ministry of Health, the VIP National Management Team and other key government departments involved in strategies, resourcing and developments, to reduce the rate of child abuse and neglect and intimate partner violence experienced within New Zealand families and whānau. It also contributes to the whole of government priorities on protecting vulnerable children[25] and Whānau Ora.[26]

In this report we present the VIP evaluation data for the period 1st July 2017 to 30st June 2018, including historical data for analysis of trends over time. Evaluation data (a) measures programme infrastructure indicators; (b) measures service delivery consistency and quality in Ministry of Health targeted services and (c) fosters system improvements.

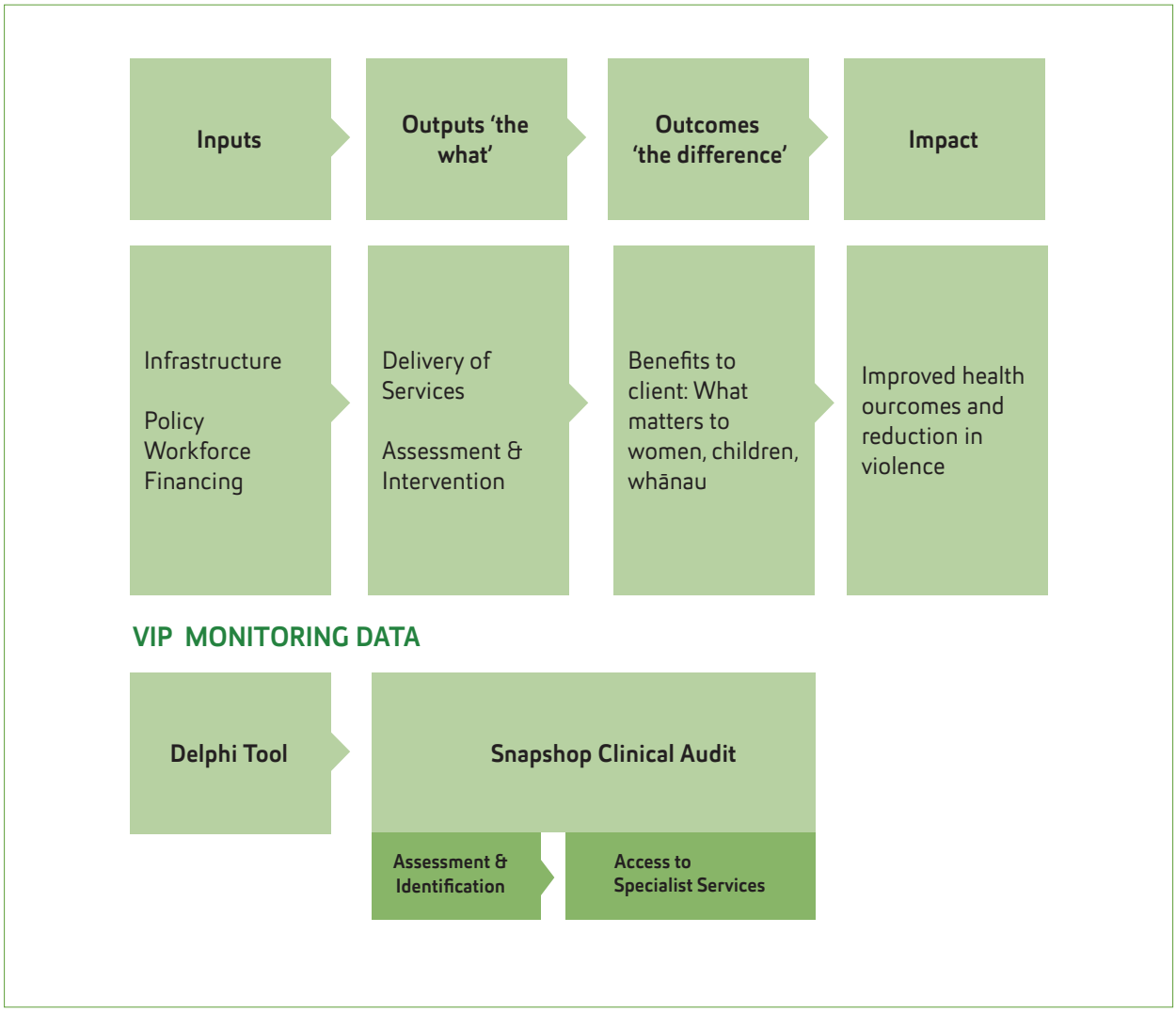


Figure 2. VIP Evaluation Monitoring Data Sources

METHODS

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

Evaluation procedures are based on a philosophy of supporting programme leaders in building a culture of improvement.[12,27] Details of the evaluation processes are outlined in Figure 3 and Appendix C. The 2018 VIP Programme evaluation commenced in August 2018 with a letter from the Ministry advising DHBs of the upcoming audit round sent to all DHB VIP Portfolio and Service Managers. On 3 September 2018, the AUT Evaluation Team sent emails advising DHBs of the audit requirements for the 2018 VIP programme evaluation. Evaluation data was due from DHBs 30 September 2018.

DHBs completed their evaluation data (submitting Delphi infrastructure audit file, completing online Snapshot clinical audits and submitting PDSA plans) between September 2018 and January 2019. 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.

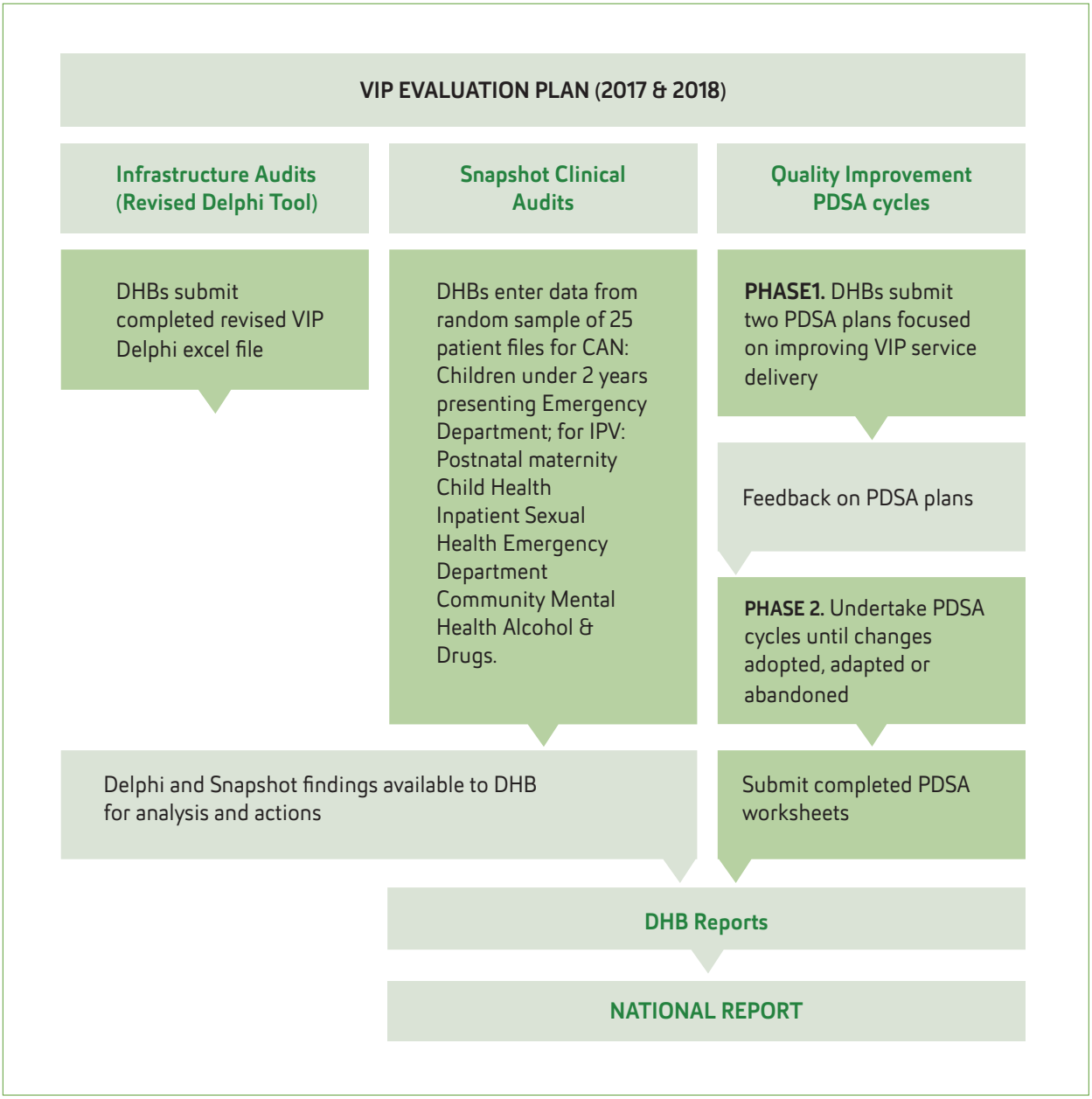


Figure 3. 2017–2018 VIP Evaluation Plan (PDSA = Plan, Do, Study, Act)

DELPHI SYSTEM INFRASTRUCTURE AUDIT

Scaling up a quality, sustainable health response to family violence is reliant on quality systems.[4–10] The VIP infrastructure tool was revised in 2017. DHBs were invited to submit VIP revised Delphi tool self-audit data covering the one-year period 1 July 2017 to 30 June 2018.

This was the first national application using the revised Delphi tool. The revised tool was developed by a panel of experts 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-six 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, allowing users to see measurement notes, enter their indicator data and instantly receive their scores to inform improvement planning. The tool is to be completed by DHB 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).

Based on pilot testing the revised tool in three DHBs, we expected DHBs to score in the 60s or 70s. New VIP infrastructure elements included in the revised tool are expected to be implemented over time.

Table 1. Revised VIP Delphi tool domains and scoring weight (MoH=Ministry of Health)

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**

Analysis

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 3.5.3). Score calculations were confirmed between Excel and R. In this report we present overall and domain scores. We demonstrate central tendency and spread using boxplots. See Appendix D for how to interpret boxplots

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.[28]

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

Benchmarking

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

- System reliability is achieved when a standard action occurs at least 80% of the time.[29] Therefore, the VIP aims to achieve IPV and CAN assessment rates ≥ 80%.
- Based on the prevalence of CAN indicators (such as a child protection alert), 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.[30,31] The estimated New Zealand population past year IPV prevalence rate among women is ≈ 5%.[32,33] The prevalence of IPV reported by women receiving health care services is higher than the population prevalence in both international and New Zealand research.[34–38] This is not surprising given the negative impact of IPV on health.[39] The VIP expects IPV disclosure rates among women seeking health care to be at least 5%.

NOTE: With several years of historical Snapshot clinical audit data, the IPV disclosure rate benchmark has been revised beginning in 2019 (see Chapter 4, Table 3).

Selected Services

The Snapshot audits in 2018 included one service for child abuse and neglect assessment and intervention; and six services for IPV assessment and intervention.

Child Abuse & Neglect Clinical Audit Service:

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

Intimate Partner Violence Clinical Audit Services:

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

Across all DHBs, there are ten service locations that are either provided by NGOs (e.g, sexual health and alcohol and drug), not provided by the DHB, or amalgamated.

Sampling and Eligibility

Within each DHB, for each selected service, a random sample of 25 eligible records during the three-month audit period (**1 April – 30 June**) were retrospectively reviewed by DHB VIP staff or delegates. Therefore, the Snapshot involved each DHB reviewing a total of 175 clinical records each year. The population (sampling frame) included all eligible visits. Therefore, women or children could be included more than once.

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

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

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

Data Elements

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

- DHB, site, and service
- Total number of eligible visits (by women or children – depending on service) in the designated service during the three-month audit period 1 April to 30 June.
- 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 were able to be recorded, consistent with Ministry of Health standard[40].
- Child's Age (ranging between 0 – 16 years) for child health inpatient service only.
- Adult's Age and Triage Status for Adult Emergency Department only
- Partner Abuse variables:
    - IPV screen (yes or no)
    - IPV disclosure (yes or no)
    - IPV referral (active (onsite), passive (offsite) or none).
- Child Abuse and Neglect variables:
    - Child Protection risk assessment (yes or no)
    - Child Protection concern identified (yes or no)
    - Child Protection consultation (yes or no).

Analysis

Snapshot data were exported from the secure web-based server in an excel file and imported into R (Version 3.5.3). Descriptive analysis was conducted for each data element. For reporting ethnicity, data was prioritised for Māori (Māori and non-Māori).

For each service, a national mean assessment rate and 95% confidence intervals were derived from individual DHB rates weighted by the number of clients seen in the designated service per DHB during the period. Data were then extrapolated to provide national estimates of the number of health clients seeking care within the services during the audit period who received VIP assessment. Identification of child protection concern and disclosure of IPV, along with consultation and referral rates were calculated similarly. 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, for timely feedback to services. An overview of VIP Snapshot data was presented to the National Network of the Violence Intervention Programme in November of 2018 to 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 quality and evaluation activities of the VIP Programme in 2015 and continues to be part of the AUT Programme Evaluation process.

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

Two PDSA plans were requested to be submitted for approval by the AUT Evaluation Team prior to implementation (i.e. writing up the PLAN phase before undertaking the DO, STUDY, and ACT phases of the PDSA cycle). They were directed to be aimed at improving service delivery using their Snapshot results. PDSA cycles were to improve rates of family violence assessment or specialised consultation, or cultural responsiveness for Māori. A PDSA pack (including a template, resource and instructions) was distributed and ongoing support, coaching and feedback was provided by the Evaluation Team. DHBs were to submit two PDSA plans to evaluators by 30 September 2018. Completed PDSA worksheets were to be submitted by 10th December 2018.

FINDINGS: SYSTEM INFRASTRUCTURE (DELPHI)

Overall Score

Across the 20 DHBs, the overall infrastructure (revised Delphi) score ranged from 43 to 91. The typical (median) score was 71. Twenty percent of DHBs scored 83 or higher. The spread of scores are shown in Figure 4, with DHBs anonymised.

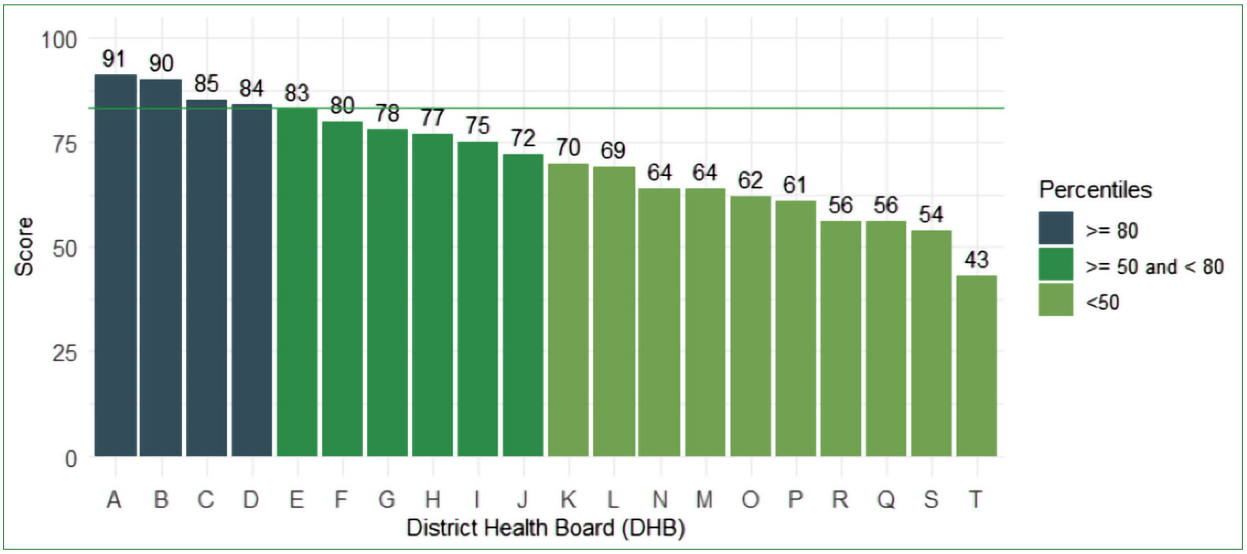


Figure 4. Programme Scores 2017–2018

Domains

Consistently high scores across DHBs were evident in the *Policies & Procedures* (median=100) and *Documentation* (median=100) domains (Figure 5). We attribute these high domain scores to the significant effort by DHB and national VIP staff during the evaluation period to update policies, procedures and standardised documentation to align with the revised 2016 *Family Violence Assessment and Intervention Guideline: Child Abuse and Intimate Partner Violence*.[2]

The *Quality Improvement* (median=50) and *VIP Practices* (median = 57) domains indicate areas for further infrastructure support and development. Frequencies for individual programme tool indicators are provided in Appendix F. Within the *Quality Improvement* domain, while 19 DHBs (95%) reported making changes in the past 12 months based on staff, community or user feedback, only six DHBs (30%) reported that the Violence Intervention Programme was included in their quality and risk strategic plan. In addition, only 6 DHBs (30%) reported using a Māori quality framework (such as Whānau Ora) to evaluate whether services are effective for Māori. This gap was also identified within the *Cultural Responsiveness* domain items.

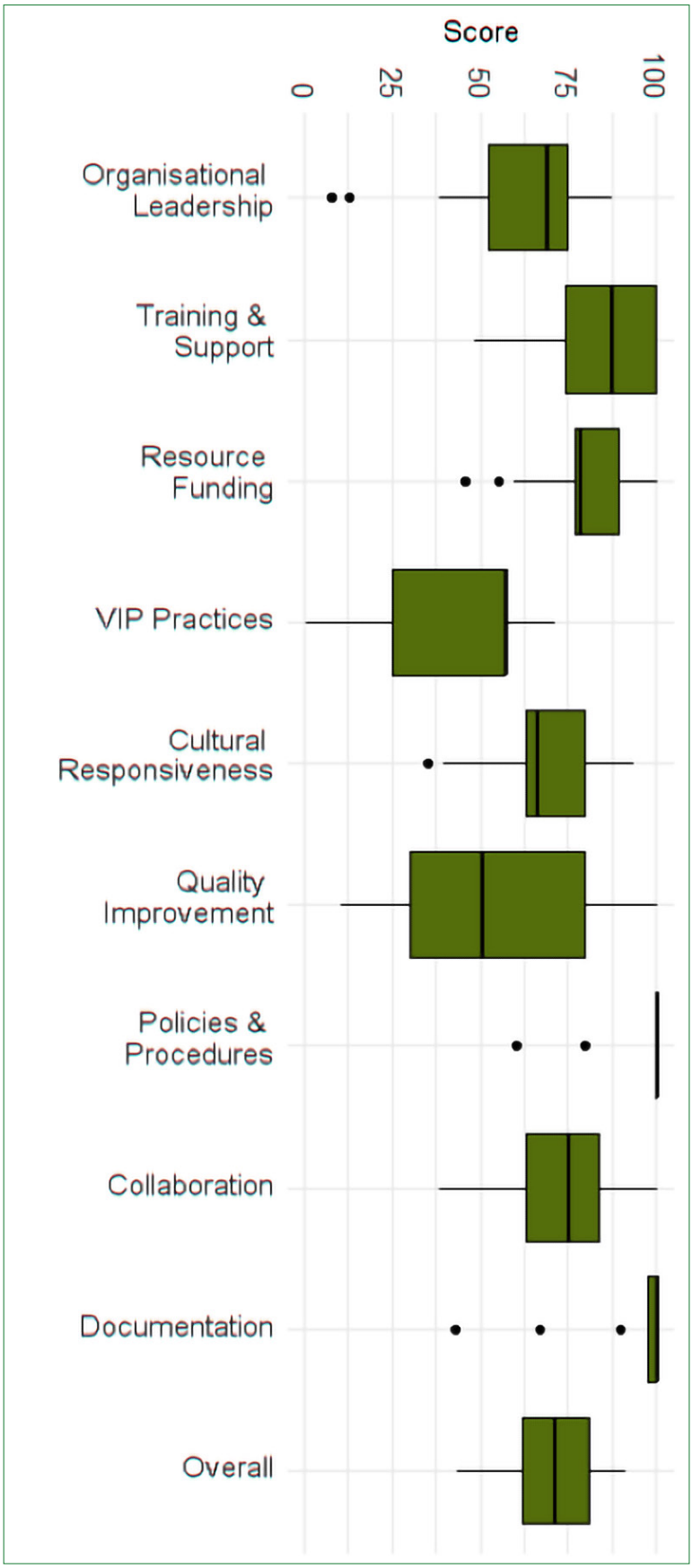


Figure 5. Domain and Overall Scores 2017–2018

FINDINGS: SNAPSHOT (CLINICAL AUDITS)

CHILD ABUSE & NEGLECT ASSESSMENT & INTERVENTION

DHB Results

In 2018, 20 DHBs (100%) provided data from 22 emergency department (ED) locations. They reported that a total of 16,643 visits by children under two years presented for any reason to the emergency department during the three-month audit period (1 April – 30 June 2018). Random sampling from the 22 locations resulted in 502 ED visits audited for the 2018 CAN Snapshot.

The child abuse and neglect Snapshot child protection assessment rate, for visits by children under two presenting to ED for any reason, ranged from 0% to 100% across the DHBs (Figure 6). Three DHBs had a zero assessment rate in their Snapshot sample while three DHBs (Capital & Coast, Counties Manukau, and Hutt Valley) achieved the target assessment rate of ≥ 80%. Among those assessed, rates of identifying a child protection concern ranged from 0% to 50% (Figure 7). Five DHBs (Canterbury, Counties Manukau, Lakes, Northland, and South Canterbury) had a child protection concern rate of ≥ 15%.

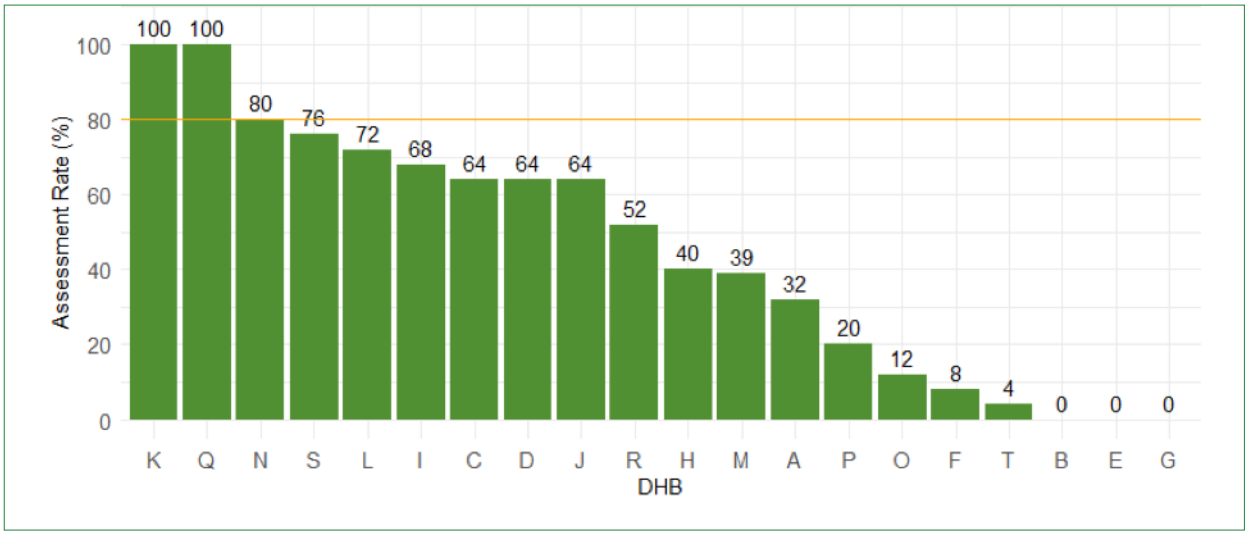


Figure 6. DHB emergency department 2018 (April–June) child abuse & neglect **assessment rates** for children presenting under 2 years of age

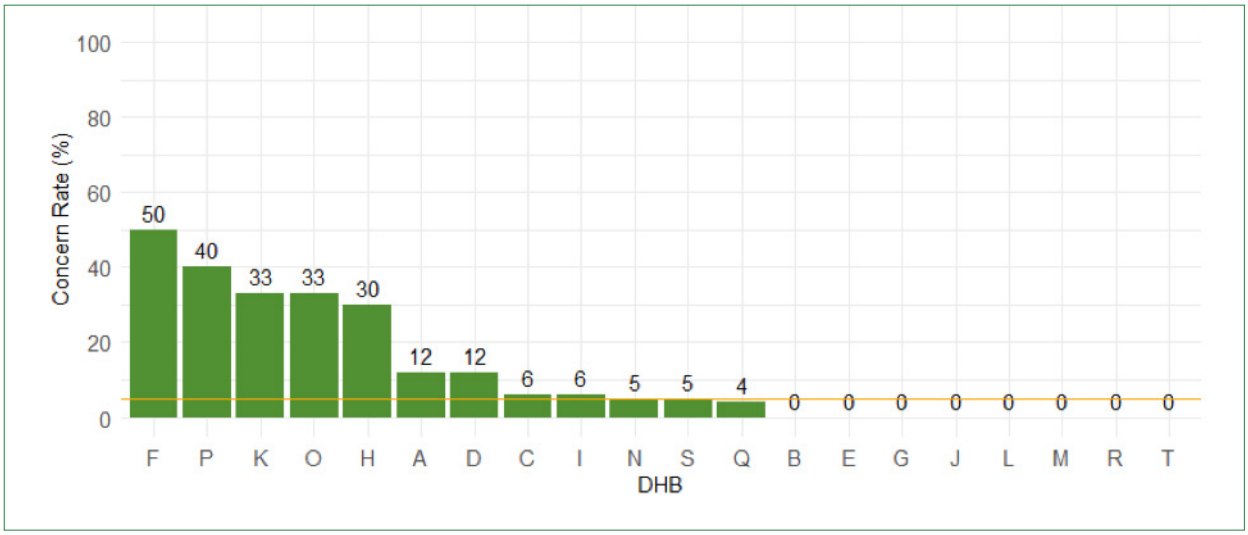


Figure 7. DHB emergency department 2018 (April–June) child protection concern rates for children under 2 years of age

The association between assessment and concern rates is shown in Figure 8. Two DHBs (Counties Manukau and Hutt Valley) achieved a CAN assessment rate ≥ 80% with a CAN concern rate ≥ 15%. 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. The Counties Manukau and Hutt Valley examples, however, demonstrate what can be achieved.

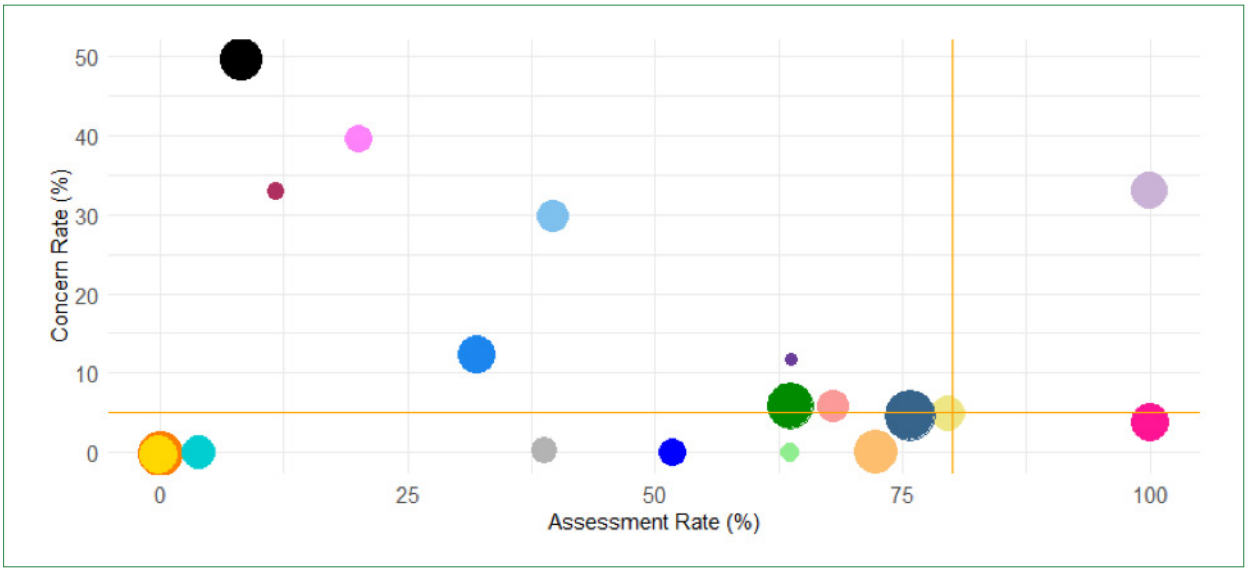


Figure 8. DHB emergency department 2018 (April–June) child abuse and neglect assessment and concern rates for visits by children under 2 years of age. **Note:** Some points include more than one DHB

National Estimates

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

- **In 2018, 48% included a child protection assessment.** This is an increase from 39% in 2017 and 26% in 2016 (Figure 9 and Table 2).
- Nationwide, approximately eight thousand (7953) visits by children included a child protection assessment during the 2018 audit period.

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

- **In 2018, a child protection concern was noted for 9%.** Over the five Snapshot audits, the mean concern rate has only varied between 9% and 13%.
- Nationwide, we estimate a concern about safety was identified in over 700 (742) visits by children during the 2018 audit period.

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:

- **In 2018, 96% received a specialist consultation.** This rate has varied between 89% (2014) and 100% (2015 and 2017).
- Nationwide, we estimate that 690 visits by children included specialist consultation for a child protection concern during the 2018 audit period.
- Despite the small variation in rate of identifying a child protection concern over the five year period 2014 to 2018, the increasing rate of assessment meant that many more children presenting to the emergency department were assessed and their cases reviewed with a senior specialist.

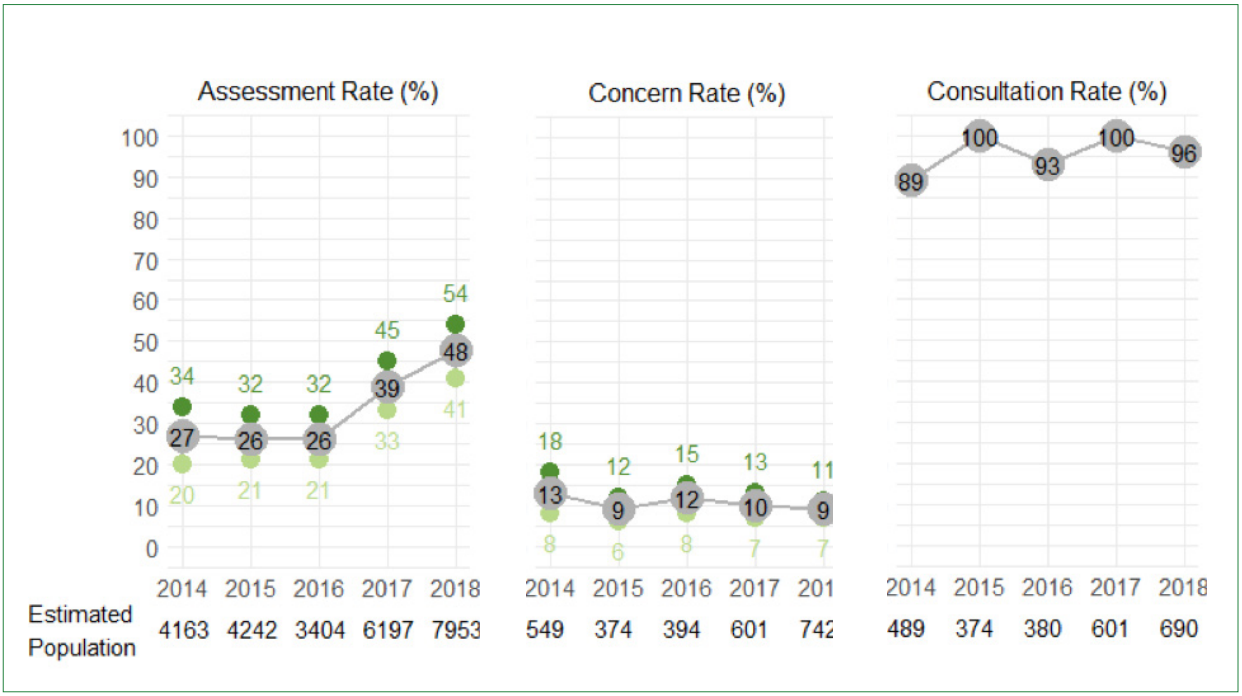


Figure 9. DHB emergency department child abuse and neglect assessment and concern rates for children under 2 years of age (2014–2018)

Table 2. Emergency department population estimates of children under two years of age who received child abuse and neglect (CAN) assessment and service (April – June, 2014 - 2018)

	Children assessed for CAN indicators					CP Concern (≥1 positive indicator)					Specialist Consultation				
	2014	2015	2016	2017	2018	2014	2015	2016	2017	2018	2014	2015	2016	2017	2018
Weighted mean	27%	26%	26%	39%	48%	13%	9%	12%	10%	9%	89%	100%	93%	100%	96%
95% CI	20%, 34%	21%, 32%	21%, 32%	33% 45%	41%, 54%	8%, 18%	6%, 12%	8%, 15%	7%, 13%	7%, 11%	*	*	*	*	*
Population estimate	4163	4242	3404	6197	7953	549	374	394	601	742	489	374	380	601	690
95% CI					6845, 9061					582, 901	*	*	*	*	*

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

INTIMATE PARTNER VIOLENCE ASSESSMENT AND INTERVENTION

IPV service delivery data is visualised in Figure 11 (next page) and provided in Appendix G tables.

Assessment. During the three-month audit period (April–June 2018):

- The proportion of eligible women's visits that included an IPV assessment ranged from 32% (95% CI 27, 37) in the emergency department to 69% (95% CI 53, 85) in sexual health.

Disclosure. During the three-month audit period (April–June 2018), among visits by women assessed for IPV:

- The proportion of visits in which women disclosed IPV ranged from 3% (95% CI 1, 4) in postnatal maternity to 30% (95% CI 23, 37) in alcohol and drug services.
- Nationwide, during the three-month audit period, we estimate that approximately 10 thousand (9889) visits by women included a disclosure of IPV to a health worker across the six targeted services.
- Due to the consistently higher disclosures in some services over time, the IPV disclosure benchmark has been increased for 2019 (see Table 3).

Referrals. During the three-month audit period (April–June 2018), in visits among women who disclosed IPV:

- The proportion who received a specialist referral ranged from 58% in sexual health to 95% in community mental health.
- Nationwide, we estimate that approximately 9 thousand (8676) visits by women who disclosed IPV to their health worker included a specialist referral.

National estimates indicate that most women who received specialist family violence services in 2018 during the three-month audit period were referred through the emergency department (n=7,031), community mental health (495) or sexual health (425) services. These services have IPV disclosure rates greater than 5%; in addition, the emergency department has high patient volumes (Figure 12, next page). The proportion of active referral to specialist IPV services (e.g., social worker, community family violence NGO) ranged between 48% (sexual health) and 77% (emergency department) as shown in Figure 10.

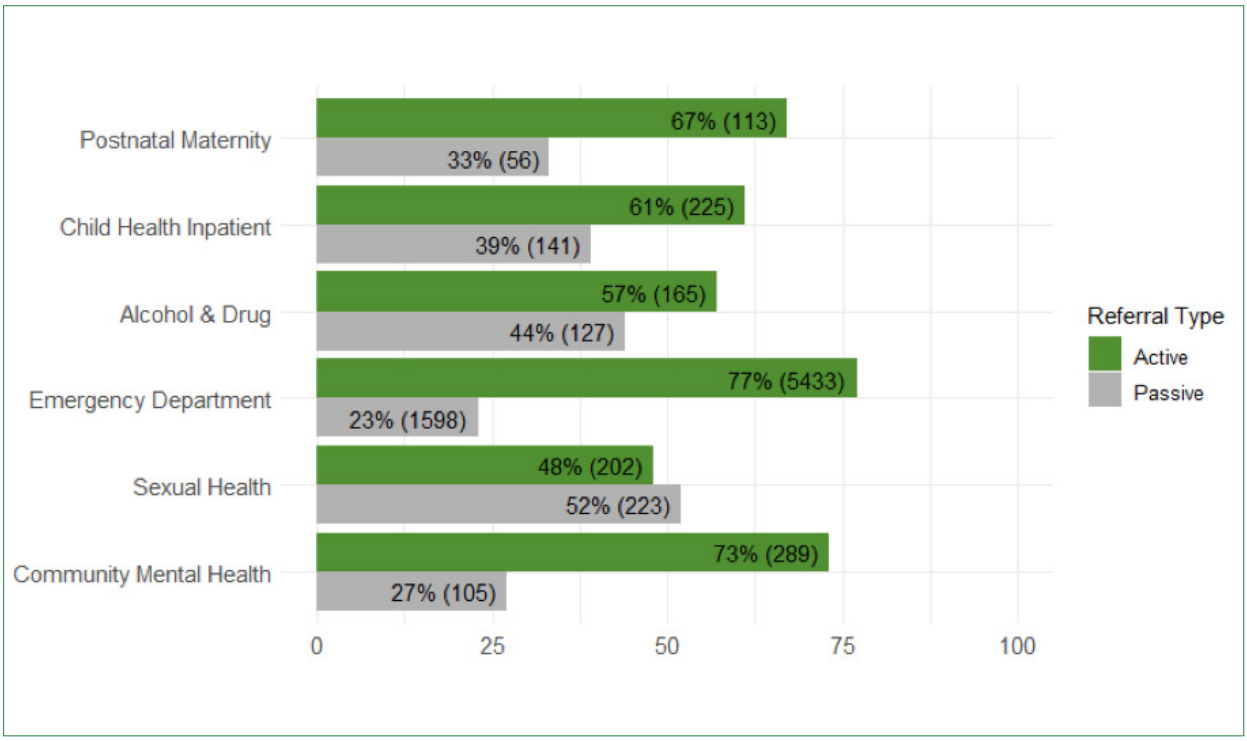
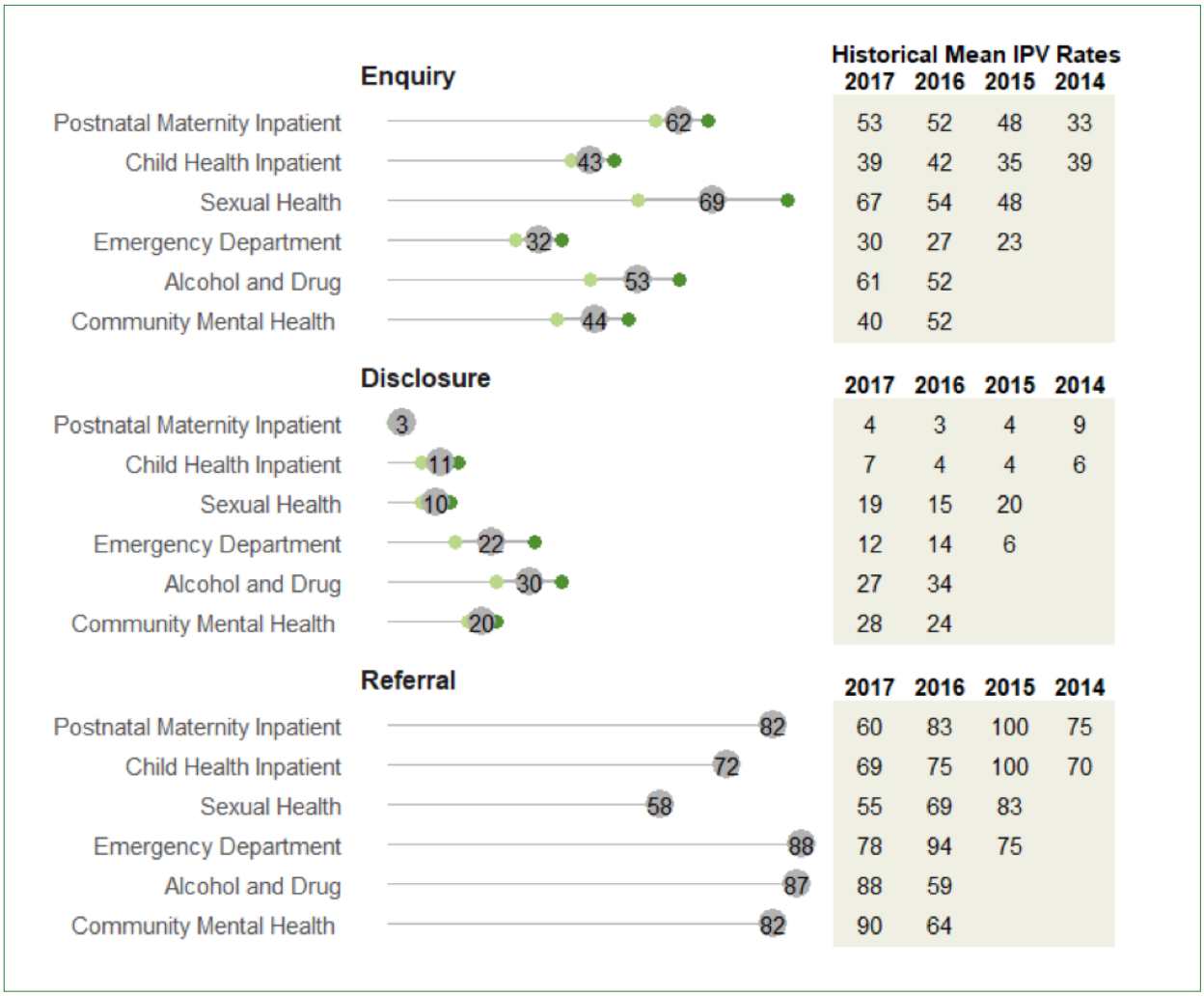


Figure 10. IPV Referral types by service (2018)



Historical Mean IPV Rates

	2017	2016	2015	2014
Postnatal Maternity Inpatient	53	52	48	33
Child Health Inpatient	39	42	35	39
Sexual Health	67	54	48	
Emergency Department	30	27	23	
Alcohol and Drug	61	52		
Community Mental Health	40	52		

	2017	2016	2015	2014
Postnatal Maternity Inpatient	4	3	4	9
Child Health Inpatient	7	4	4	6
Sexual Health	19	15	20	
Emergency Department	12	14	6	
Alcohol and Drug	27	34		
Community Mental Health	28	24		

	2017	2016	2015	2014
Postnatal Maternity Inpatient	60	83	100	75
Child Health Inpatient	69	75	100	70
Sexual Health	55	69	83	
Emergency Department	78	94	75	
Alcohol and Drug	88	59		
Community Mental Health	90	64		

Figure 11. New Zealand estimates of women who received intimate partner violence (IPV) assessment and intervention across DHB services (April – June 2014 to 2018)

As stated earlier in this report, an IPV routine enquiry rate of 80% or greater is indicative of system reliability; and given the population prevalence, a disclosure rate of 5% or greater is expected as an indicator of screening quality. Snapshot average scores in 2018 did not meet the target zone for any of the six services (Figure 12).

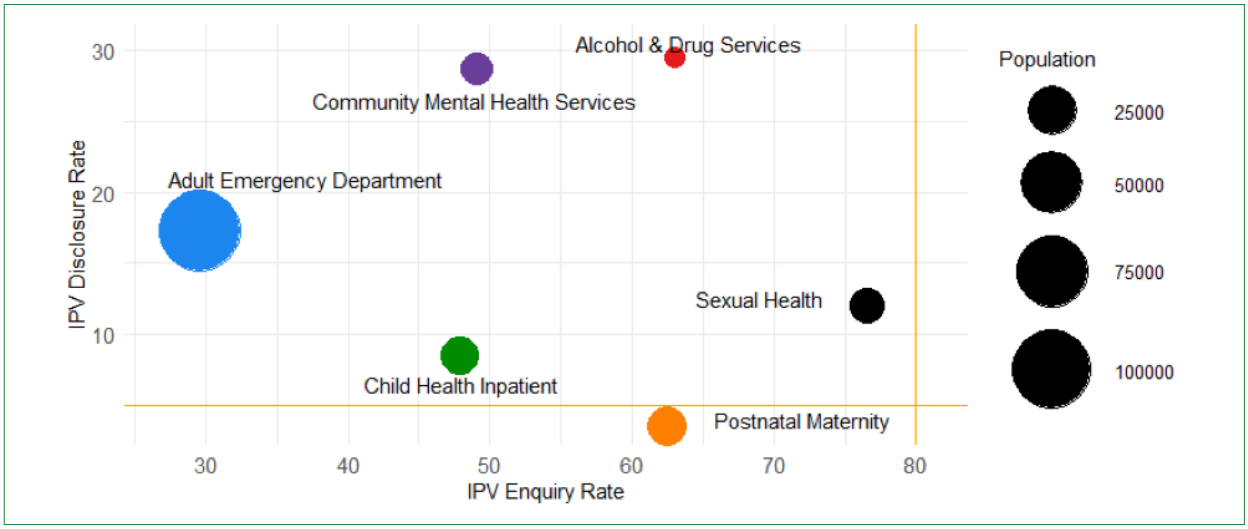


Figure 12. National 2018 average (weighted) intimate partner violence routine enquiry and disclosure rates (April–June). **Note:** Circle size represents the total population of the service.

Average assessment and disclosure rates mask variability in service delivery. In 2018, there were 18 service locations that achieved IPV assessment rates ≥ 80% and disclosures rates ≥ 5% (within the target zone; see Appendix H). These were located in 9 DHBs. This was an increase from 11 service locations in 2017. The 2018 rate of achieving the benchmark was 16% based on 110 VIP service locations assessed in the Snapshot audit (20 DHBs X 6 services less 10 contracted out services). Service detail is provided in the following sections.

Due to the pattern of consistently higher disclosures in some service over time (Figure 11), the disclosure benchmark has been increased for 2019 in all services with the exception of postnatal maternity (see Table 3). The benchmarks were determined based on rounding of the 70th percentile among those reporting at least a 30% assessment rate.

Table 3. Future Snapshot benchmarks for IPV disclosure and CAN concern

	Current Benchmark	2019 Benchmark
IPV Disclosure Rates		
Postnatal Maternity	5%	5%
Child Health Inpatient	5%	10%
Alcohol & Drug	5%	15%
Emergency Department	5%	15%
Sexual Health	5%	15%
Community Mental Health	5%	25%
CAN Concern Rates		
Child Abuse & Neglect	5%	15%

POSTNATAL MATERNITY

Postnatal Maternity DHB Results

Across the 20 DHBs, 12,103 women were admitted to postnatal maternity services during the three-month Snapshot audit period (1 April – 30 June 2018). Random sampling from the 21 locations (one DHB reported on two locations) resulted in 527 cases audited for the 2018 Snapshot.

The VIP postnatal maternity snapshot IPV routine enquiry rates ranged from 36% to 96% across DHBs (Figure 13). Two DHBs achieved the target IPV routine enquiry rate of ≥ 80% (Bay of Plenty and West Coast).

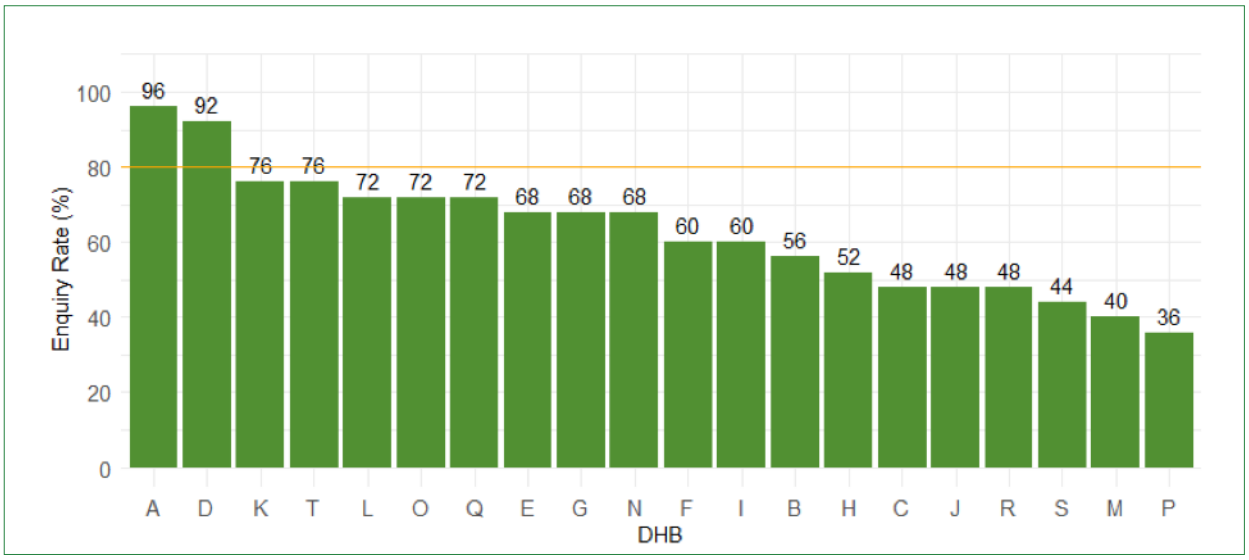


Figure 13. DHB postnatal maternity 2018 (April–June) intimate partner violence routine enquiry rates

Among women who received an IPV routine enquiry, IPV disclosure rates ranged from 0% to 17% (Figure 14). Five DHBs (Counties Manukau, Southern, Tairawhiti, Waikato, and Wairarapa) met the expectation that at least one of every twenty women who received an IPV routine enquiry would disclose intimate partner violence.

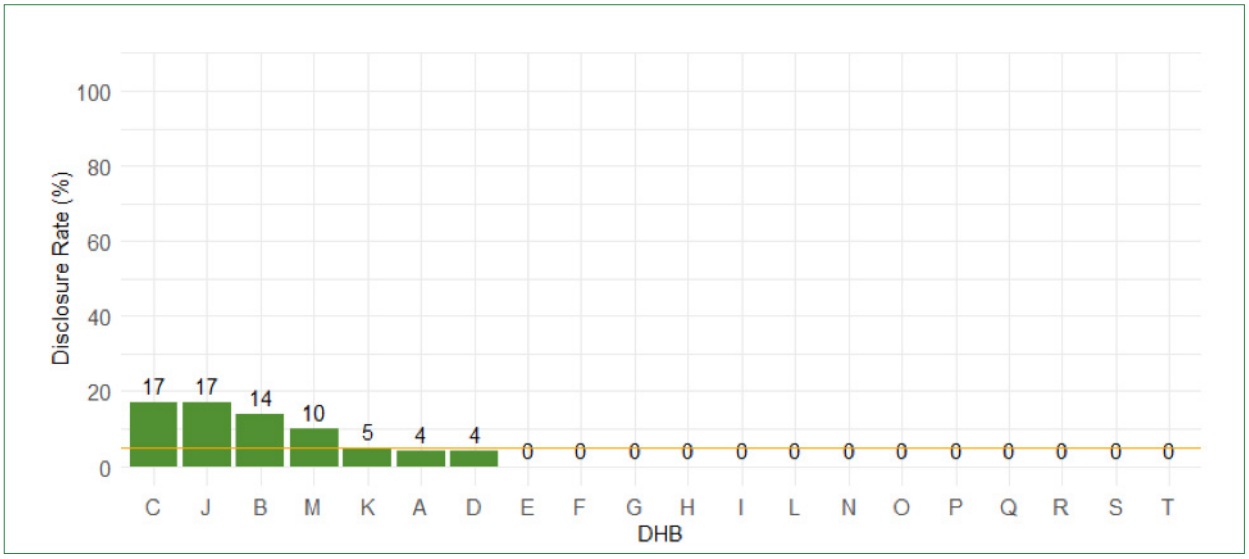


Figure 14. DHB postnatal maternity 2018 (April–June) intimate partner violence disclosure rates

The relationship between assessment and disclosure rates is graphed in Figure 15. In postnatal maternity services, no DHBs achieved the benchmark of ≥ 80% IPV routine enquiry rate with ≥ 5% disclosure rate.

Two DHBs (Bay of Plenty and West Coast) achieved a high IPV routine enquiry rate (96% and 92% respectively), with a disclosure rate nearing 5% (4%); and a third DHB (Counties Manukau) with a routine enquiry rate > 70% and a disclosure rate >5%. For the majority of DHBs, however, no women in the Snapshot sample had disclosed IPV.

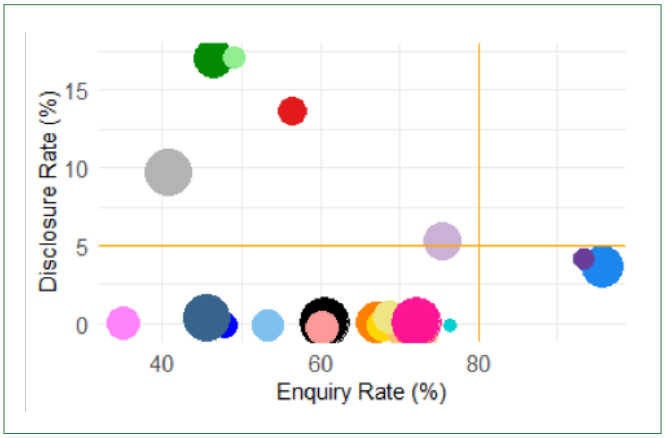


Figure 15. DHB postnatal maternity 2018 (April–June) Intimate Partner Violence routine enquiry and disclosure rates (N=20) **Note**: Some points include more than one DHB

Postnatal Maternity National Estimates

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

- **In 2018, 62% of women were assessed for IPV.** There has been a year on year increase in IPV assessment in the postnatal maternity service between 2014 and 2018 (Figure 16).
- Nationwide, we estimate heath workers conducted an IPV assessment with 7,531 women during the 2018 audit period.

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

- **In 2018, the IPV identification rate was 3%.** After a 9% identification rate in 2014 (occurred when assessment rate was 33%), the identification rate has been stagnant at 3–4%.
- Nationwide, we estimate IPV was identified in 191 women during the 2018 audit period.

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

- **In 2018, 82% received a specialist referral/ consultation.**
- Nationwide, we estimate 169 women were provided specialist IPV consultation or referral. Among these, 113 (67%) were active referrals to on-site specialist services and 56 were passive referrals to an offsite specialist service.
- Despite increasing rates of IPV assessment in postnatal maternity services over time, the number of women disclosing IPV and thus having access to specialist services is small (ranging from 125 women in 2016 to 232 women in 2017).

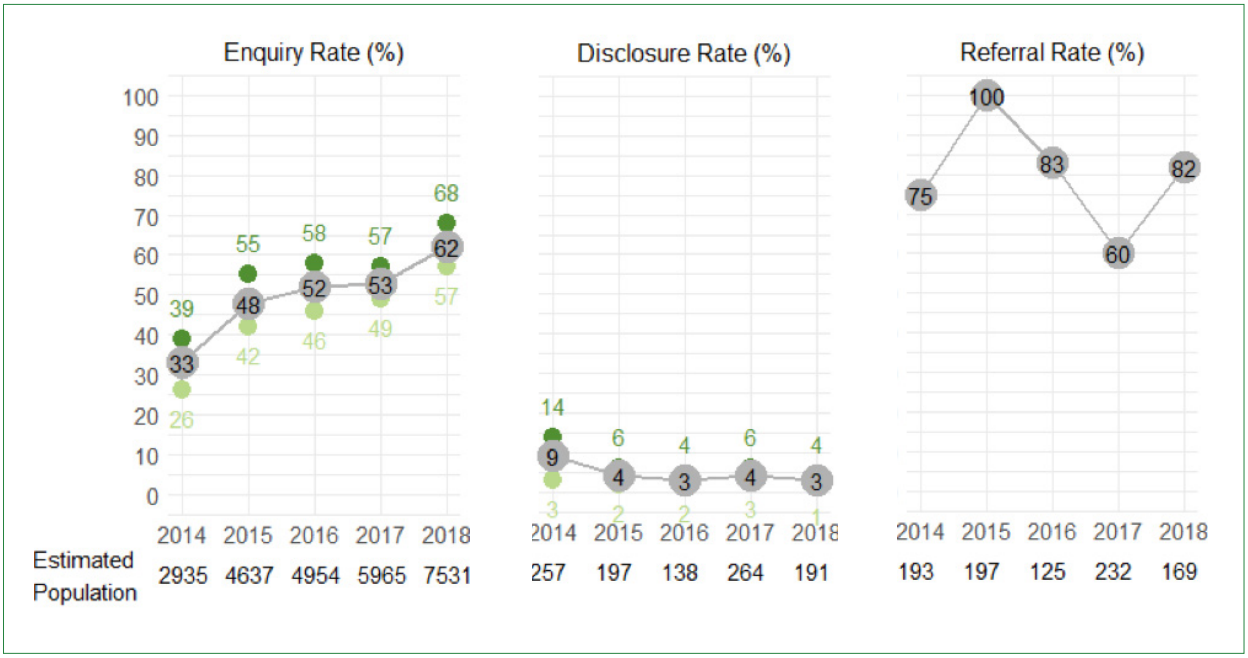


Figure 16. DHB postnatal maternity Intimate Partner Violence routine enquiry and disclosure, and Referral rates (2014–2018)

CHILD HEALTH INPATIENT

Child Health DHB Results

Nationally, 20 DHBs provided data from 20 child health inpatient locations. They reported a total of 10,716 admissions by children during the three-month audit period (1 April – 30 June 2018). Random sampling from the 20 locations resulted in 501 admissions audited for the 2017 Snapshot.

The IPV child health inpatient snapshot routine enquiry rate of female parents, guardians or caregivers, ranged from 12% to 84% (Figure 17). Three DHBs achieved the target IPV routine enquiry rate of 80% (Counties Manukau, Taranaki, and Whanganui).

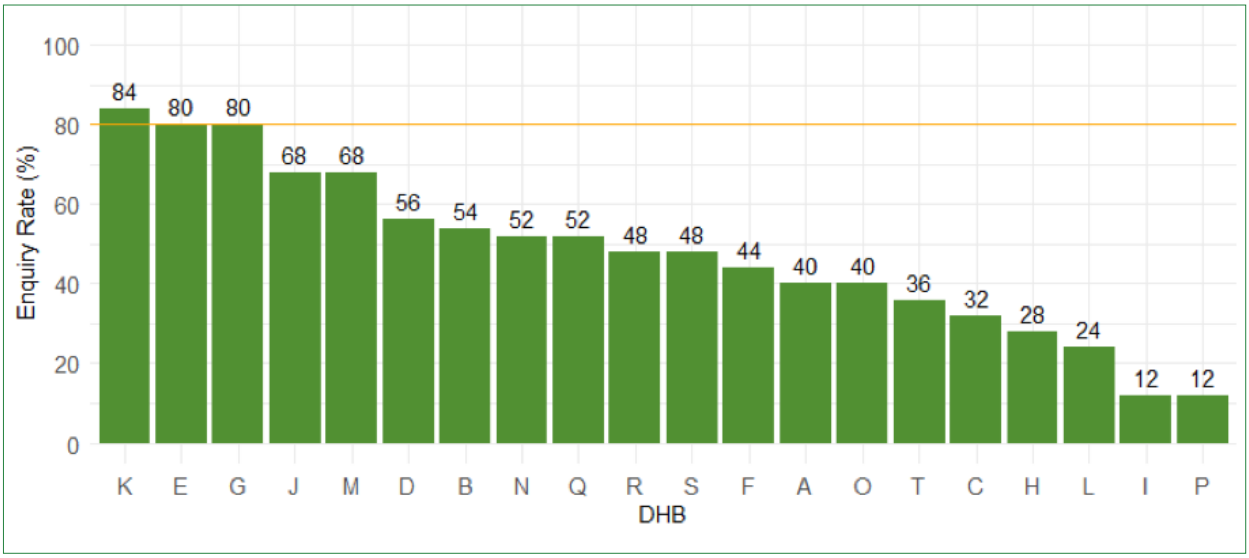


Figure 17. DHB child health 2018 (April–June) intimate partner violence routine enquiry rates

Among women who received an IPV routine enquiry, disclosure rates ranged from 5% to 33% across the 11 DHBs with a non-zero IPV routine enquiry rate (Figure 18). Seven DHBs met the expectation that at least one of every twenty women who received an IPV routine enquiry would disclose abuse. The DHBs were Auckland, Bay of Plenty, Capital & Coast, Hawkes Bay, Mid Central, Waikato, and Wairarapa.

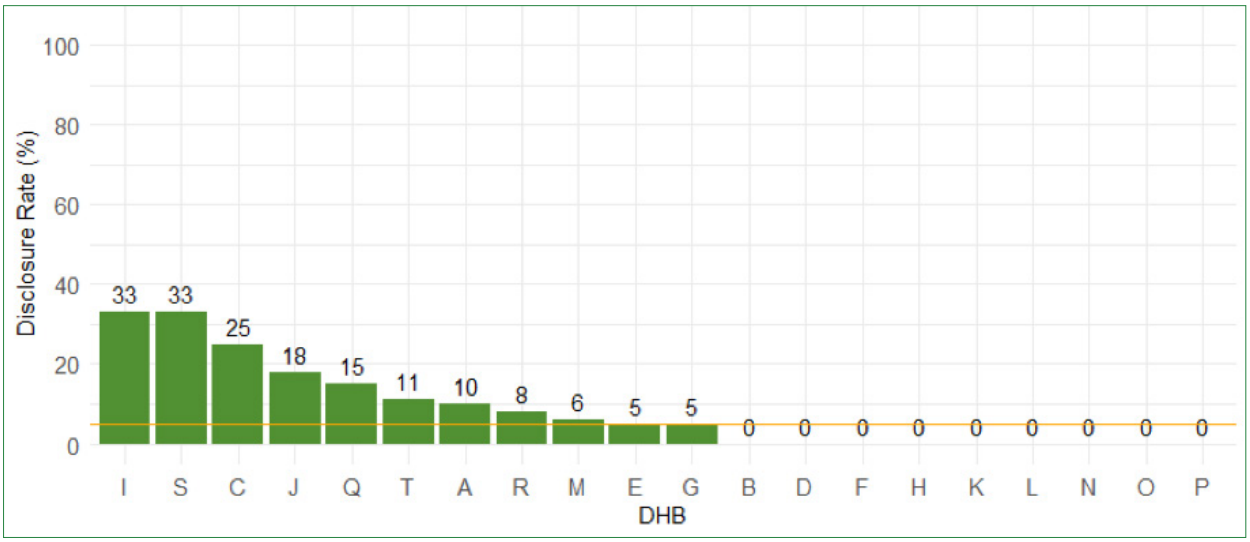


Figure 18. DHB child health 2018 (April–June) intimate partner violence disclosure rates

In child health services, two DHBs (Taranaki and Whanganui) achieved the benchmark (≥ 80% screening with ≥ 5% disclosure rate; Figure 19).

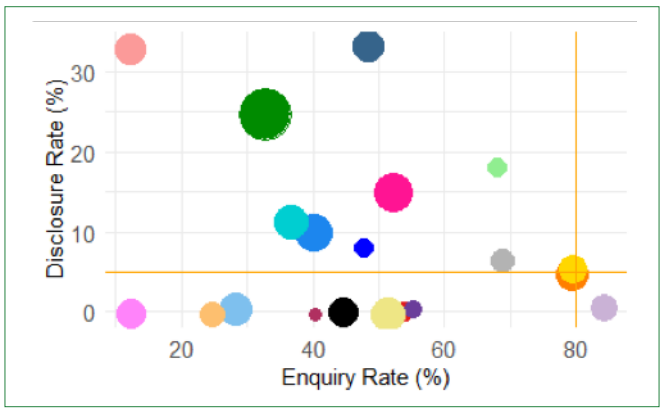


Figure 19. DHB child health inpatient 2018 (April–June) intimate partner violence routine enquiry and disclosure rates. **Note:** Some points include more than one DHB.

Based on the Snapshot weighted mean for IPV routine enquiry (43%; 95% CI 39%, 48%), we estimate that for 4,655 general paediatric ward admissions during the second quarter of 2018, female caregivers received a VIP intimate partner violence routine enquiry (see Figure 20).

Based on the Snapshot data weighted mean for IPV disclosure (11%; 95% CI 7%, 15%), we estimate that in 505 cases, women disclosed IPV to a health care provider, with 366 women (72% of those who disclosed abuse) receiving a referral for specialist services.

EMERGENCY DEPARTMENT

Nationally, 20 DHBs provided data from 20 emergency departments. They reported that 107,995 women presented to the emergency departments during the three-month audit period (1 April – 30 June 2018). Random sampling from the 20 locations resulted in 500 cases audited for the 2018 Snapshot.

The IPV emergency department snapshot IPV routine enquiry rate of women aged 16 years and over ranged from 4% to 80% (Figure 21). One DHB has not implemented VIP in their service.

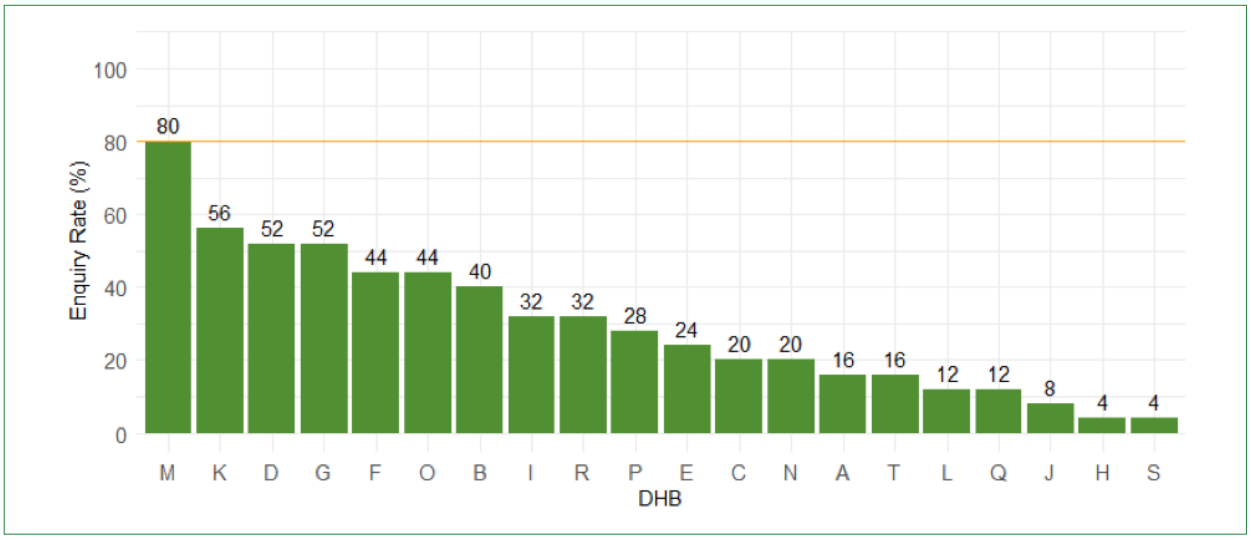


Figure 21. DHB emergency department 2018 (April–June) intimate partner violence routine enquiry rates

DHBs IPV disclosure rates ranged from 0% to 100% (Figure 22). Seven DHBs (Auckland, Bay of Plenty, Capital & Coast, Counties Manukau, Hawkes Bay, Taranaki, Whanganui) met the expectation that at least three in every twenty women screened would disclose abuse.

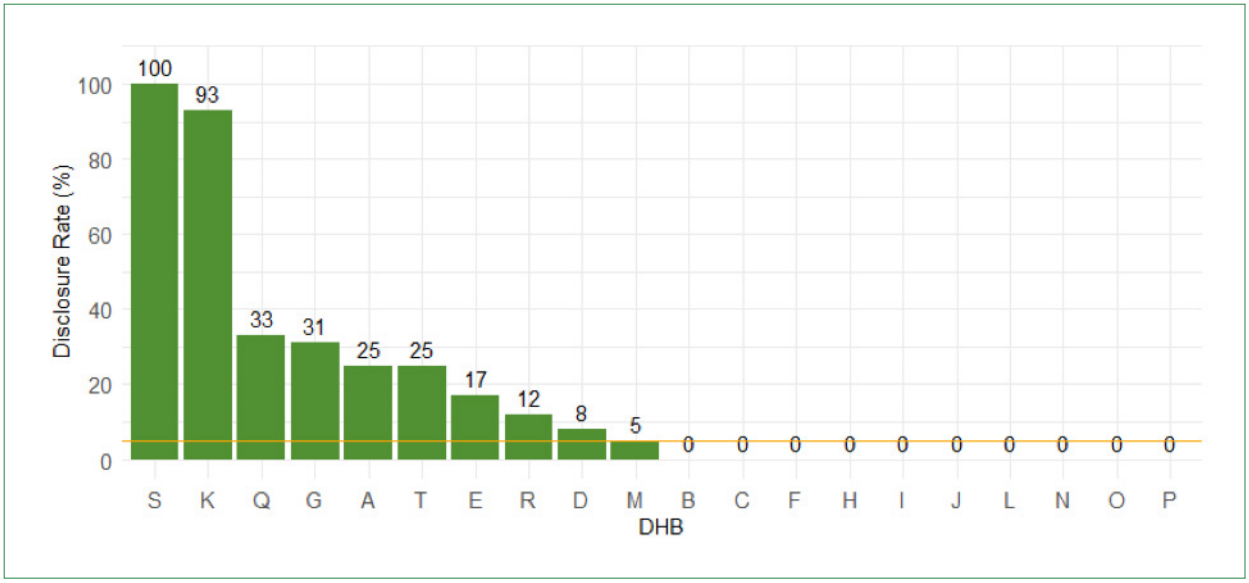


Figure 22. DHB emergency department 2017 (April–June) intimate partner violence disclosure rates

In emergency department services, one DHB (Southern) achieved the benchmark (≥ 80% IPV routine enquiry with ≥ 5% disclosure rate; Figure 23). Three DHBS achieved an IPV routine enquiry rate over 50% with disclosure rates ≥ 5% (Counties Manukau, Taranaki, and West Coast). The single DHB with 100% disclosure rate had minimal routine enquiry and most likely represents a disclosure-related identification (level 1 identification) rather than routine screening.

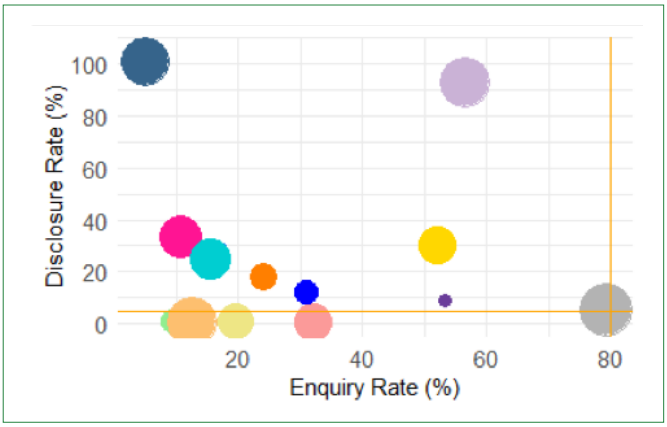


Figure 23. DHB emergency department 2018 (April–June) intimate partner violence routine enquiry and disclosure rates. **Note:** Some points include more than one DHB

Based on the Snapshot weighted mean for IPV routine enquiry (32%; 95% CI 27%, 37%) we estimate that 34,314 women who presented to the emergency department April–June 2018 received a VIP intimate partner violence routine enquiry (Figure 24).

Based on the Snapshot data weighted mean for IPV disclosure (22%; 95% CI 14%, 31%) we estimate that 7,677 women disclosed intimate partner violence to a health care provider, with 7,031 women receiving a referral for specialist services.

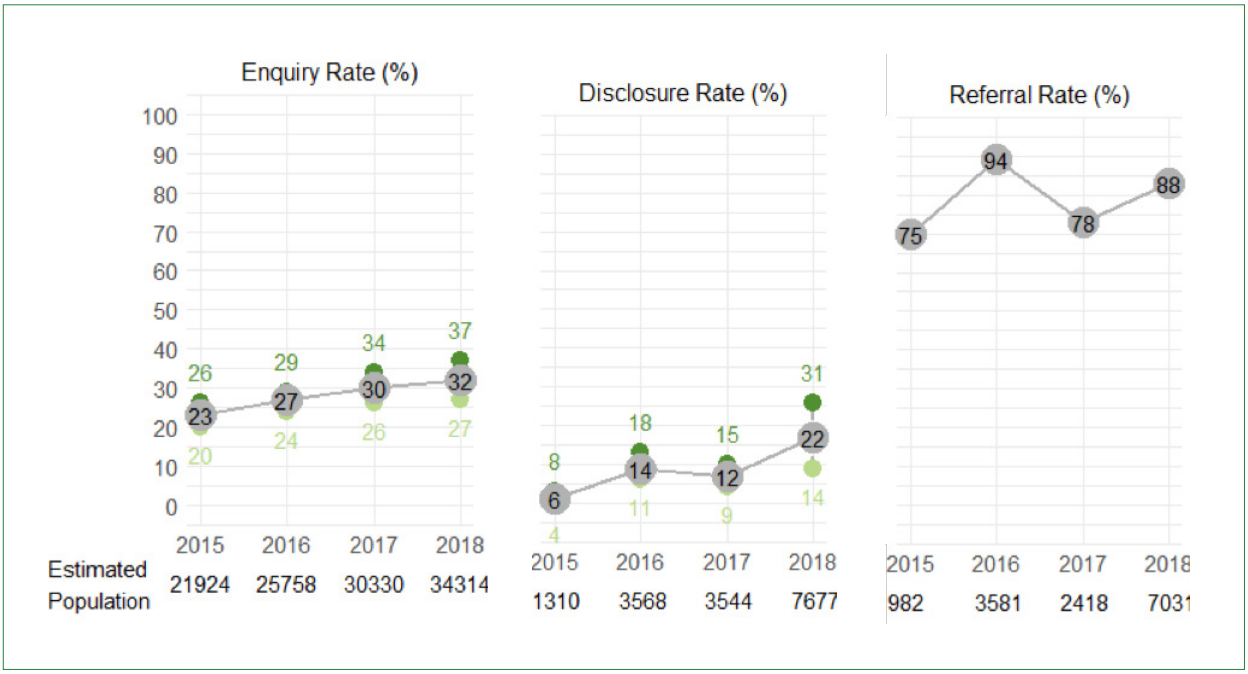


Figure 24. DHB emergency department intimate partner violence routine enquiry, disclosure, and referral rates (2014–2018)

Sexual Health Services

Nationally, 75% (n=15) of DHBs providing sexual health services submitted Snapshot data in 2018. They reported that 7,668 women presented to the sexual health service during the three-month audit period (1 April – 30 June 2018). Random sampling from the 15 locations resulted in 368 cases audited for the 2018 Snapshot.

The IPV sexual health service Snapshot IPV routine enquiry rate for women aged 16 years and over ranged from 40% to 92% (Figure 25). Nine DHBs (Bay of Plenty, Canterbury, Mid Central, Nelson Marlborough, South Canterbury, Southern, Tairawhiti, Taranaki, and West Coast) achieved the target IPV routine enquiry rate of greater than 80%.

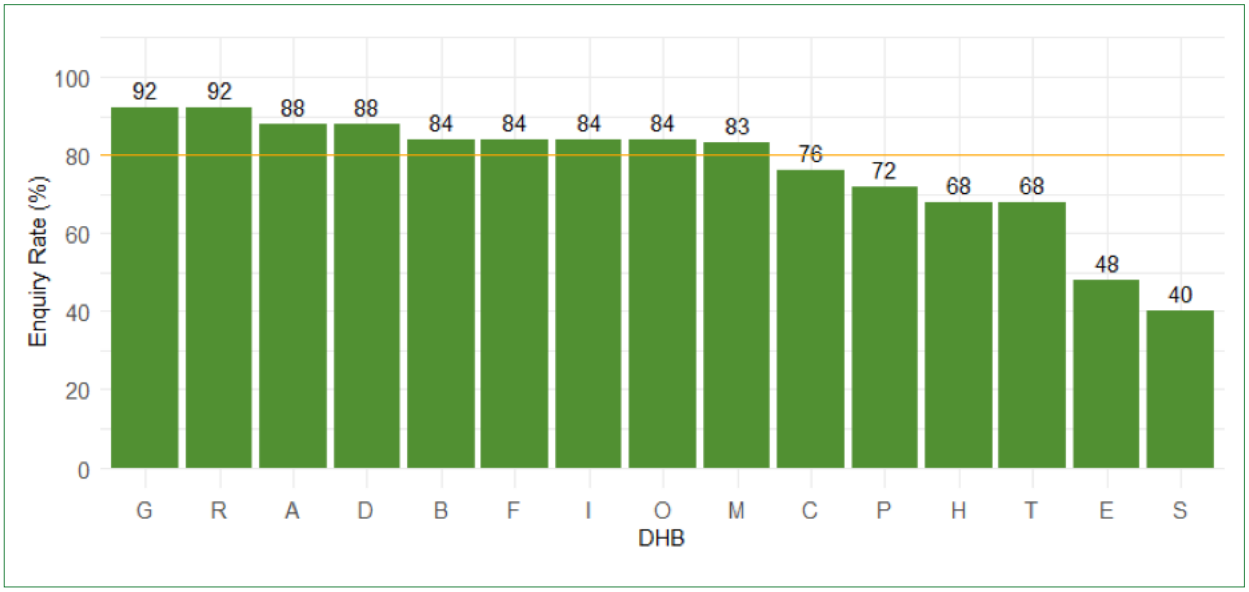


Figure 25. DHB sexual health service 2018 (April–June) intimate partner violence routine enquiry rates (n=15)

IPV disclosure rates ranged from 40% to 92% (Figure 26). Five DHBs met the future 2019 target that at least three in every twenty women screened would disclose abuse (Bay of Plenty, Lakes, Southern, Tairawhiti, Taranaki, West Coast).

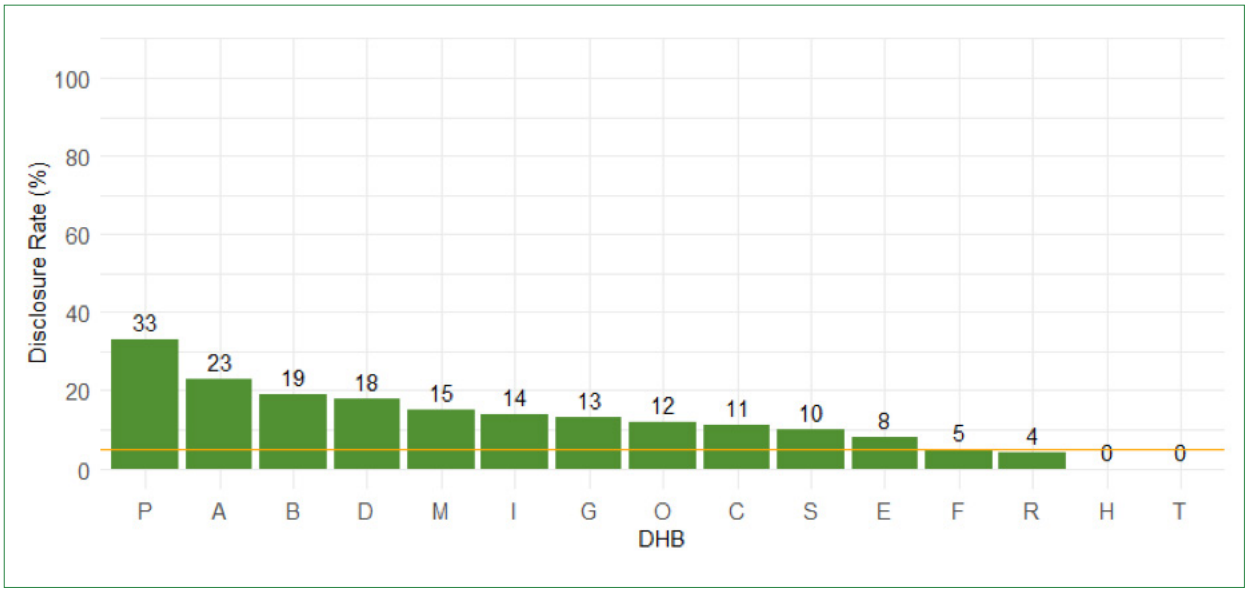


Figure 26. DHB sexual health service 2018 (April–June) intimate partner violence disclosure rates (n= 15)

In sexual health services, eight DHBs (Bay of Plenty, Canterbury, Mid Central, South Canterbury, Southern, Tairawhiti, Taranaki, and West Coast) achieved the VIP Snapshot benchmark (≥ 80% IPV routine enquiry with ≥ 5% disclosure rate; Figure 27).

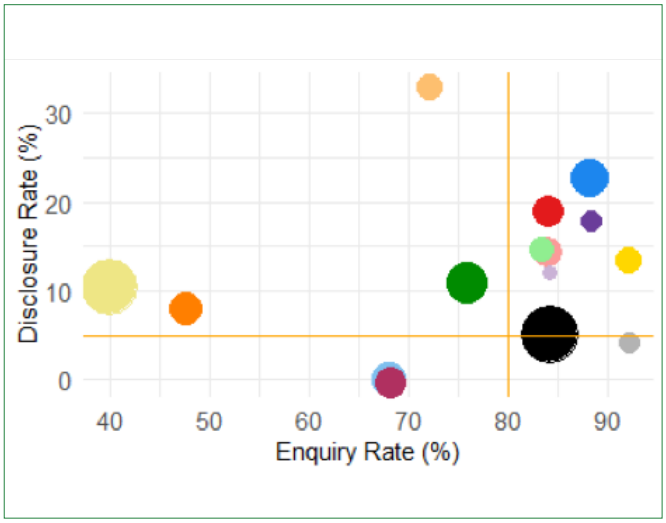


Figure 27. DHB sexual health service 2018 intimate partner violence routine enquiry and disclosure rates (n=14). **Note**: Some points include more than one DHB

Based on the Snapshot weighted mean for IPV screening (69%; 95% CI 53%, 85%), we estimate that 5,298 women presenting to the sexual health services during the second quarter of 2018 received a VIP IPV routine enquiry (Figure 28).

Based on the Snapshot data weighted mean for IPV disclosure (10%: 95% CI 7%, 13%), we estimate that 530 women disclosed intimate partner violence to a health care provider, with 425 women receiving a referral for specialist services.

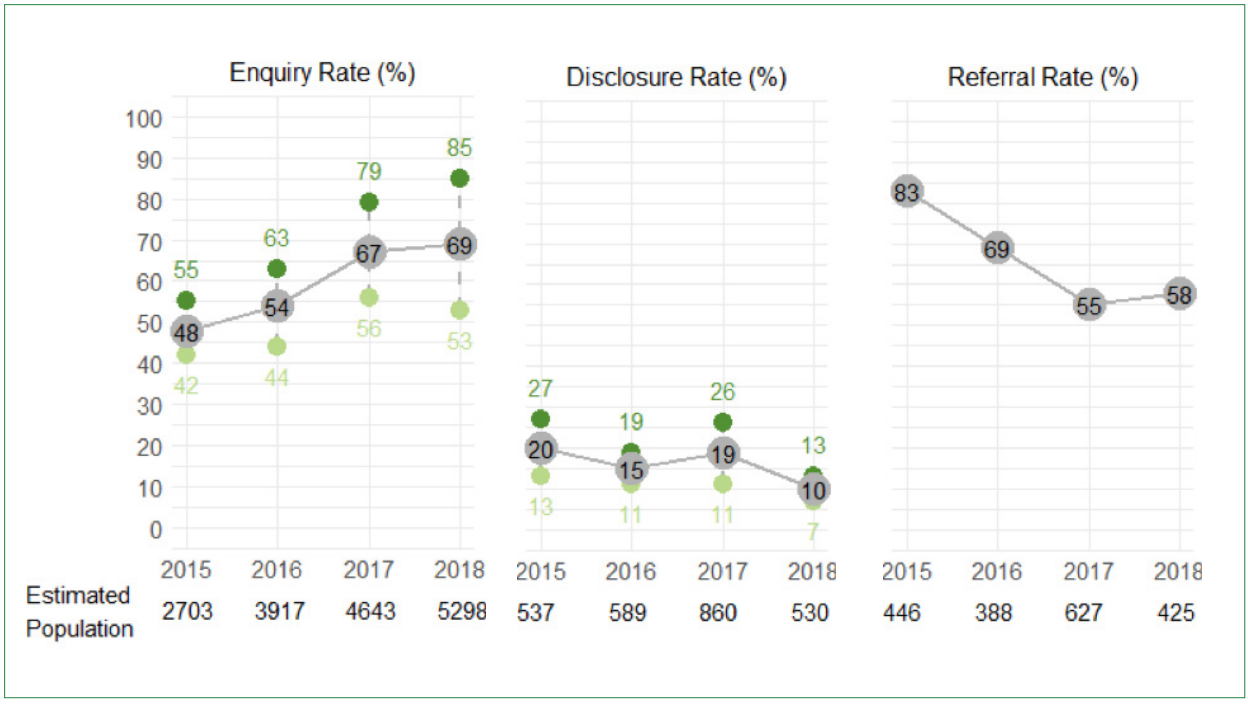


Figure 26. DHB sexual health service intimate partner violence routine enquiry and disclosure rates (2014–2018)

Community Mental Health Services

Nationally, 19 DHBs (95%) provided Snapshot data from 20 adult community mental health services in 2018. They reported that 6617 new women clients (seen for the first time by the service) and previous women clients (who had been discharged from and re-referred to the service (as if they were a new client)) aged 16 years and over presented to adult Community Mental Health Services during the three-month audit period (1 April – 30 June 2018). Random sampling from the 20 locations resulted in 495 cases audited for the 2018 Snapshot. The Ministry of Health released one DHB from the need to provide Snapshot data and one DHB did not provide data.

The IPV community mental health snapshot routine enquiry rate of women aged 16 years and over ranged from 0% to 90% (Figure 29). Four DHBs (Bay of Plenty, Mid Central, South Canterbury and Taranaki) achieved the target IPV routine enquiry rate of equal or greater than 80%.

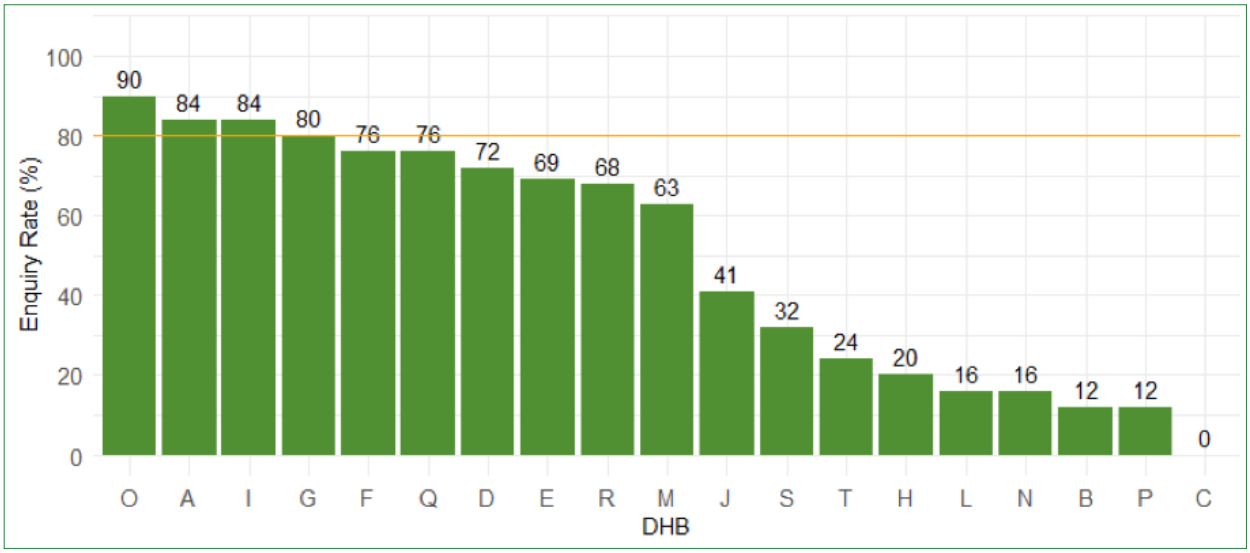


Figure 29. DHB community mental health service 2018 (April–June) intimate partner violence routine enquiry rates (n=19)

Among new women clients who received an IPV routine enquiry, in the 18 DHBs with a nonzero routine enquiry rate, IPV disclosure rates ranged from 0% to 100% (Figure 30). Sixteen DHBs (Auckland, Bay of Plenty, Canterbury, Capital & Coast, Hawkes Bay, Hutt Valley, Mid Central, Nelson Marlborough, Northland, Southern, Tairawhiti, Taranaki, Wairarapa, Waitemata, West Coast, Whanganui) met the expectation that at least one in every twenty women who received an IPV routine enquiry would disclose abuse.

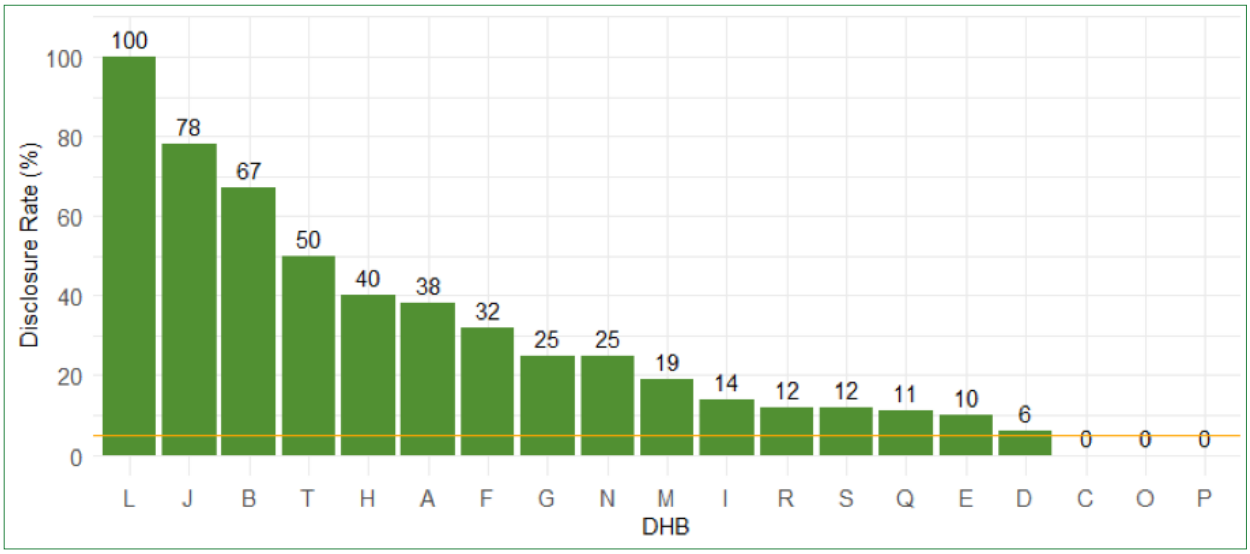


Figure 30. DHB community mental health service 2018 (April–June) intimate partner violence disclosure rates (n=19)

In adult community mental health services, three DHBs (Bay of Plenty, Mid Central and Taranaki) achieved the benchmark (≥ 80% screening with ≥ 5% disclosure rate; Figure 31).

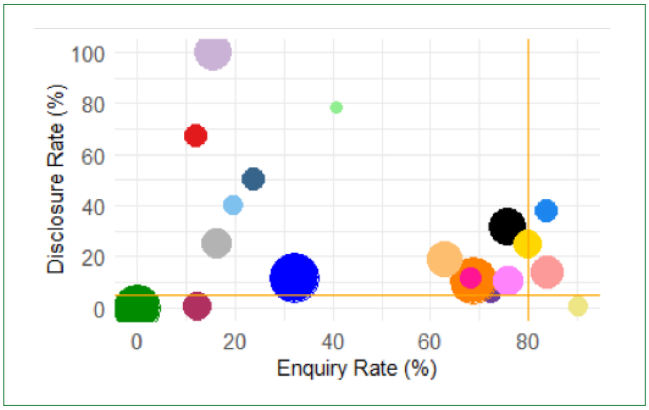


Figure 31. DHB community mental health service 2018 (April–June) intimate partner violence routine enquiry and disclosure rates (n=19). **Note:** Some points include more than one DHB

Based on the Snapshot weighted mean for IPV routine enquiry (44%; 95% CI 36%, 51%) we estimate that 2,878 women who presented to the adult community health service during the second quarter of 2018 received a VIP intimate partner violence routine enquiry (Figure 32).

Based on the Snapshot data weighted mean for IPV disclosure (20%; 95% CI 17%, 23%) we estimate that 576 new women clients disclosed intimate partner violence to a health care provider, with 394 women receiving a referral for specialist services.

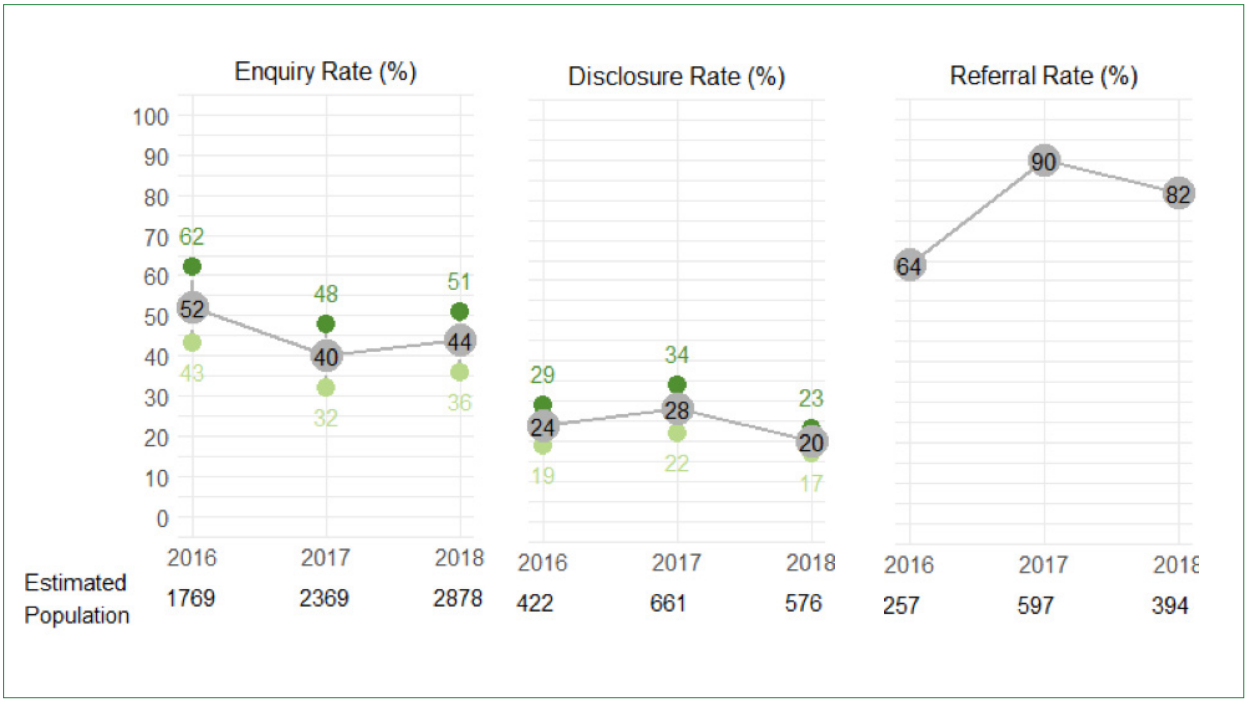


Figure 32. DHB community mental health service intimate partner violence routine enquiry and disclosure rates (2016–2018)

Community Alcohol and Drug Services

Nationally, 14 of the 16 DHBs providing community alcohol and drug services submitted Snapshot data in 2018. They reported that 2579 new women clients (seen for the first time who had completed at least one face to face contact) presented to community alcohol and drug services during the three-month audit period (1 April – 30 June 2018). Random sampling from the 14 locations resulted in 350 cases audited for the 2018 Snapshot. The Ministry of Health released one DHB from the need to provide Snapshot data and three DHBs did not provide data.

The IPV community alcohol and drug service Snapshot IPV routine enquiry rate for new women clients aged 16 years and over ranged from 0% to 92% (Figure 33). Four DHBs (Mid Central, Southern, Tairawhiti, West Coast) achieved the target IPV routine enquiry rate of greater than 80%.

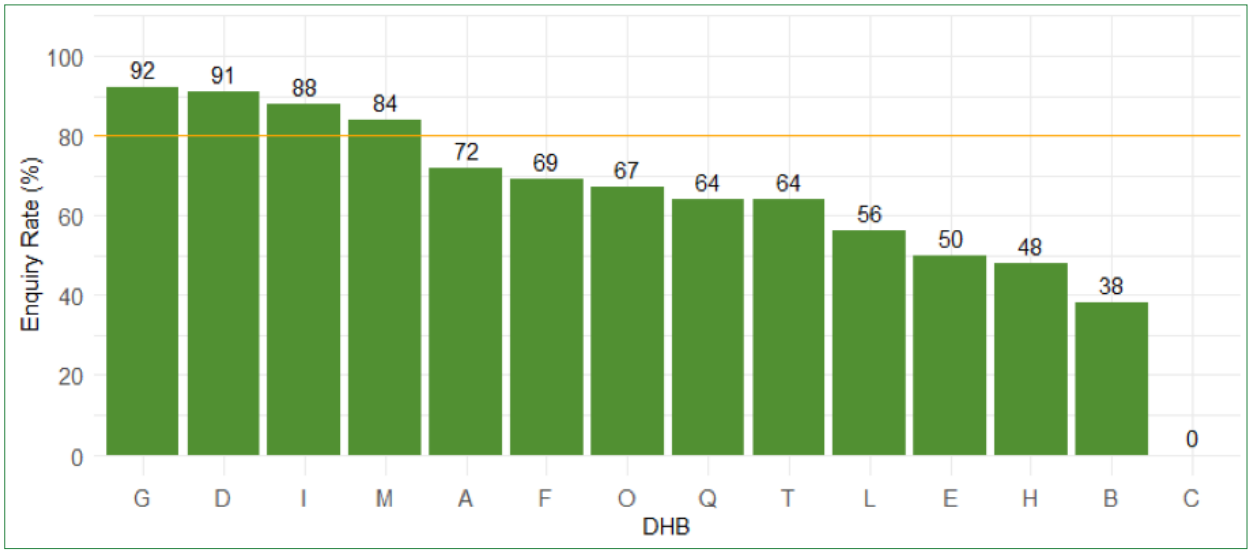


Figure 33. DHB community alcohol and drug services 2018 (April–June) intimate partner violence routine enquiry rates (n=14)

IPV disclosure rates ranged from 0% to 70% (Figure 34). All DHBs, except 2, met the expectation that at least one in every twenty women screened would disclose abuse.

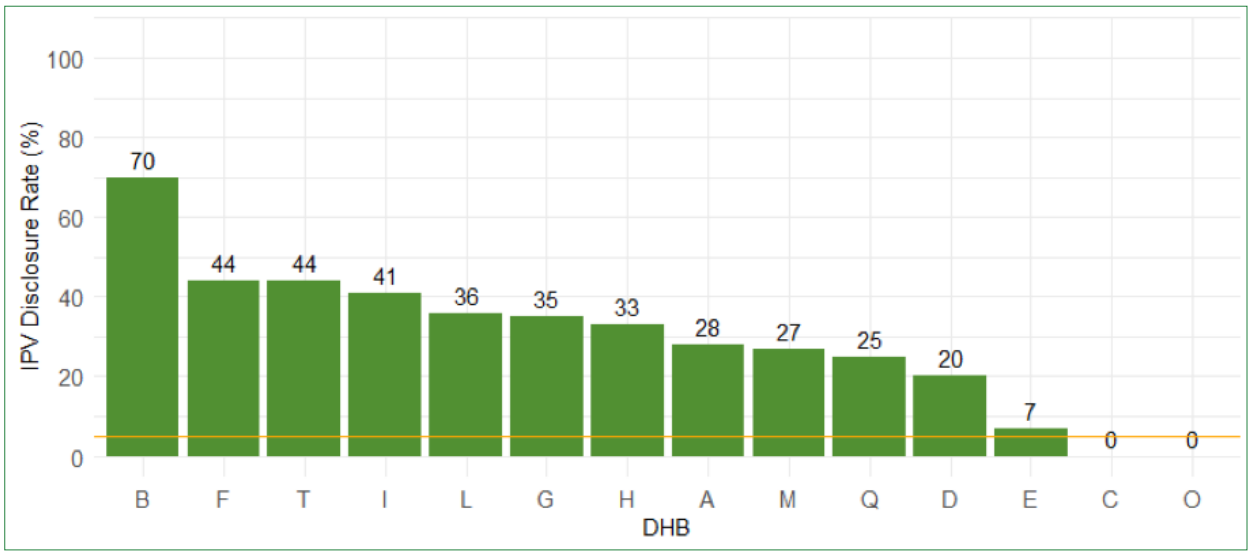


Figure 34. DHB community alcohol and drug services 2018 (April–June) intimate partner violence disclosure rates (n= 14)

In community alcohol and drug services, four DHBs (Mid Central, Southern, Taranaki, and West Coast) achieved the VIP Snapshot benchmark (≥ 80% IPV routine enquiry with ≥ 5% disclosure rate; Figure 35).

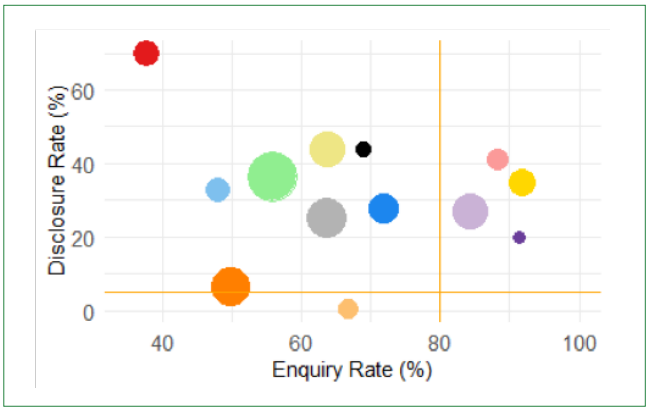


Figure 35. DHB community alcohol and drug services intimate partner violence routine enquiry and disclosure rates (n=14)

Based on the Snapshot weighted mean for IPV routine enquiry (53%; 95% CI 43%, 62%), we estimate that 1,358 new women clients presenting to community alcohol and drug services during the second quarter of 2018 received a VIP IPV routine enquiry (Figure 36).

Based on the Snapshot data weighted mean for IPV disclosure (30%; 95% CI 23%, 37%), we estimate that 291 women disclosed intimate partner violence to a health care provider, with 350 women receiving a referral for specialist services.

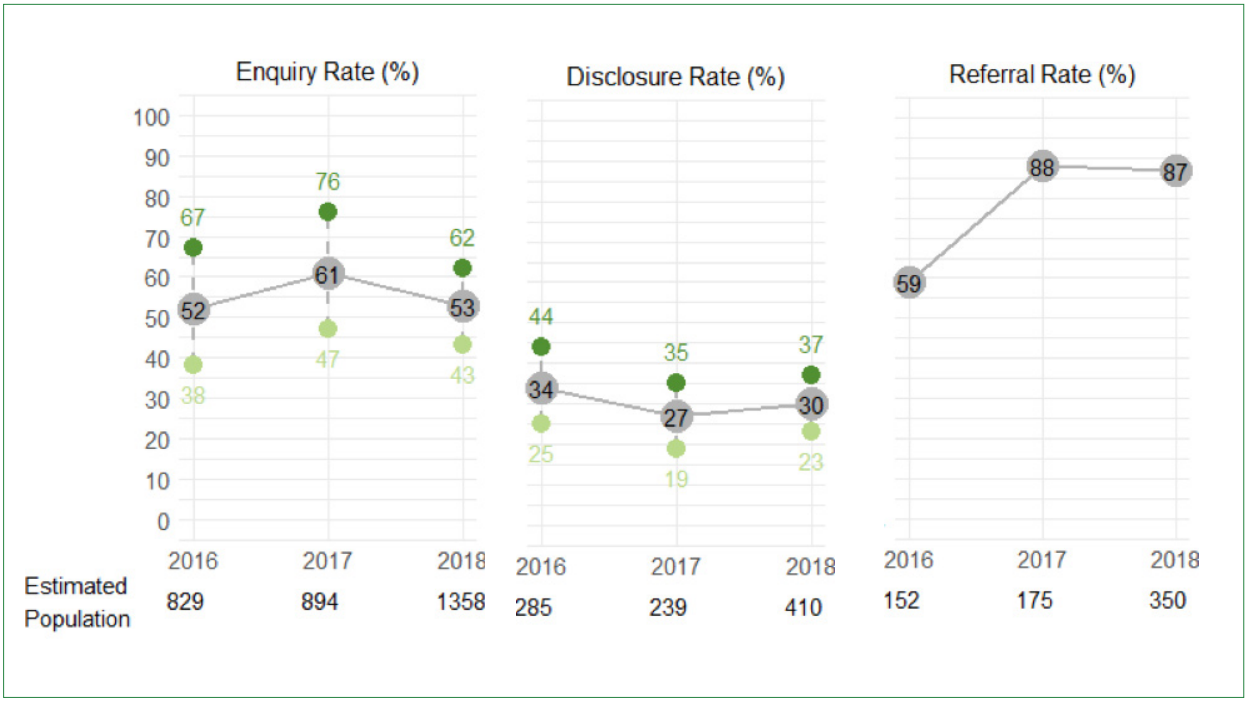


Figure 36. DHB community alcohol and drug services intimate partner violence routine enquiry and disclosure rates (2016–2018)

ETHNICITY

Māori whānau are continuing to suffer the effects of colonisation, with significant, persisting health inequities.[41,42] As a social determinant of health, family violence has reached epidemic proportions for Māori.[42] To be responsive to the significant health inequities that exist in New Zealand, particularly for tangata whenua, the VIP evaluation systematically collects and reports on infrastructure (Delphi audit) and service delivery (Snapshot) for Māori. While reporting on Māori service delivery is aligned with examining government responsibility for equal health outcomes under Te Tiriti o Waitangi, caution must be exercised in interpreting the data. Further critical analysis is necessary to better understand the sites of racism[43] embedded in standardised health system responses to family violence.

While the overall *Cultural Responsiveness* Delphi infrastructure domain score was 68 (possible range 0–100), some individual items signal the need for additional resources to support system improvements for Māori. For example:

- Only 30% of DHBs (n=6) reported that 'Feedback is sought from Māori who interact with the VIP service that specifically addresses the cultural responsiveness of the service'.
- Despite the Ministry's equity policy identifying that 'different people with different levels of advantage require different approaches and resources to get equitable health outcomes',[44] only 35% of DHBs (n=7) reported 'There is extra funding provided for people and resources specifically to reduce the impact of family violence on Māori'.

In the Snapshot clinical audits, child abuse and neglect assessment rates for Māori and non-Māori children under 2 years of age presenting to an emergency department are displayed in Figure 37. Over the past four years, Snapshot data indicates that Māori children are under assessed for child protection compared to non-Maori children, though confidence intervals are wide and overlap (Appendix I). Of note, improvement is necessary to achieve the target of assessing at least 80% of all children receiving care in emergency departments.

Intimate partner violence assessment rates were also examined for Māori and Non-Māori (Figure 38). The greatest differences in assessment rates between Māori and non-Māori in 2018 were evident in community mental health services, with Māori under-assessed (absolute difference of 26%), and in child health inpatient, with Māori over-assessed (absolute difference of 10%). Similar to assessment for child abuse and neglect, both Māori and non-Māori are under-served (less than 80% assessment rates).

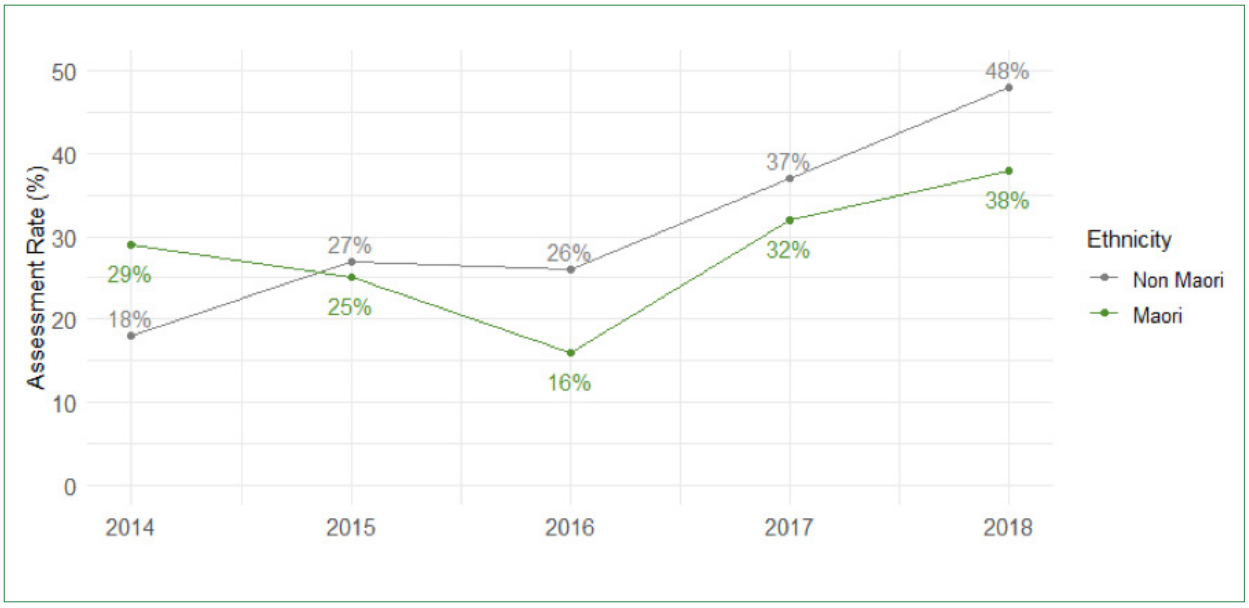


Figure 37. Child abuse and neglect assessments for children evaluated in the emergency department by ethnicity (Māori, Non-Māori) (April-June quarter, 2014 – 2018)

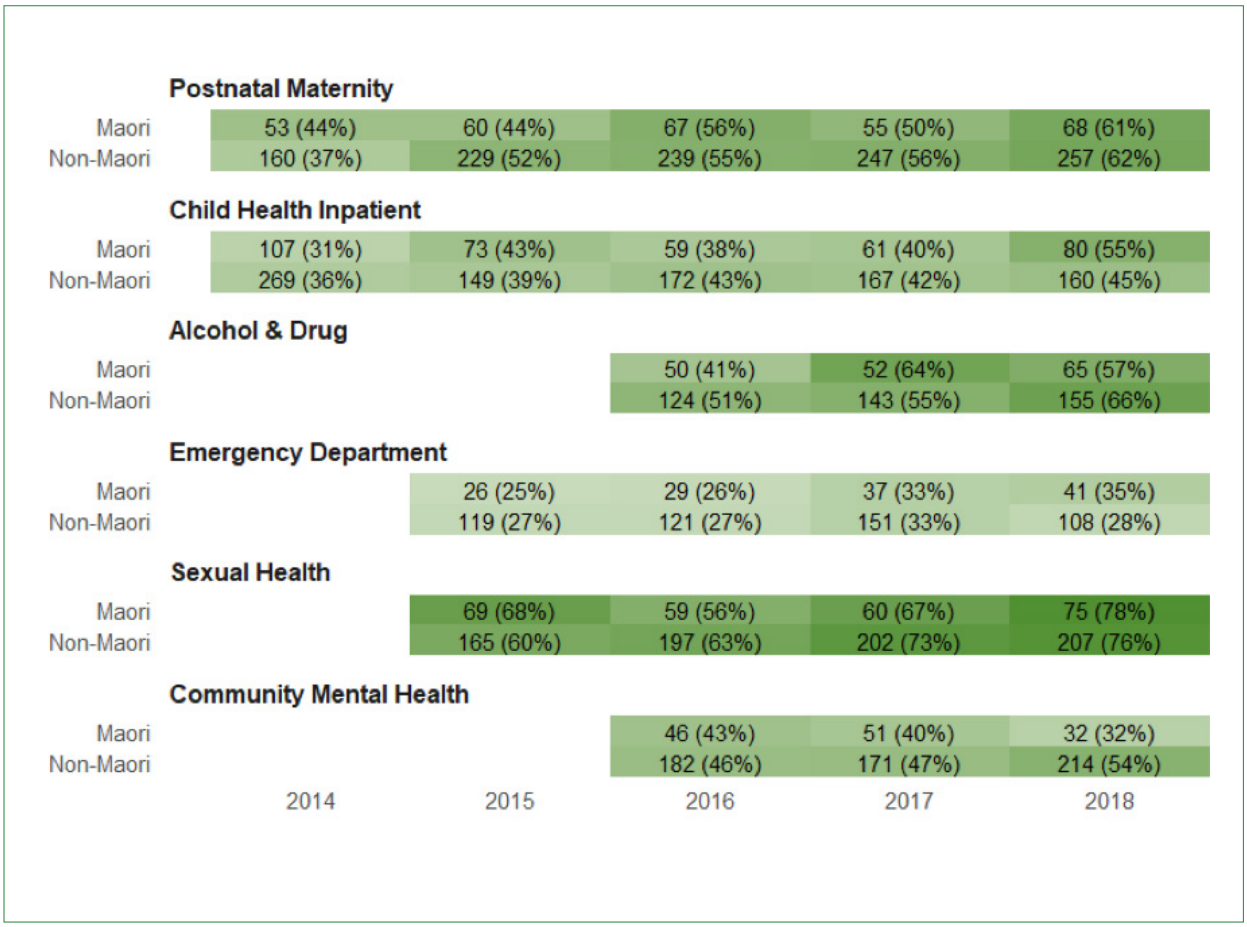


Figure 38. IPV Assessments by Ethnicity (2018)

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. Forty PDSA cycle plans were submitted, 29 of which were completed. Among those completed, 21 documented either an increased understanding of their system or a performance increase following implementing their planned change action.

Examples of successful change actions included partnering with unit management and champions to improve IPV routine enquiry; providing daily or weekly feedback to staff to improve IPV routine enquiry or child protection assessment; and chart reminders (large dots) to improve child protection assessments in the emergency department. Several DHBs tested offering post-training support, but found it resource intensive, and thus difficult to implement. While some 'nudges' were effective, new forms, digitalised forms, and training by itself rarely resulted in measured improvements.

To support ongoing learning, a Model for Improvement refresher session was offered to all VIP coordinators led by Suzanne Proudfoot (Ko Awatea) in May 2019. See the Box below for key points to improvement.

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.
   - local FV data re the scope of the problem is useful
   - understand FV as a determinant of health
   - 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.

DISCUSSION

The VIP evaluation aims to (a) measure programme infrastructure indicators, (b) measure service delivery consistency and quality in Ministry of Health targeted services and (c) foster system improvements. The health response to family violence is directed by national assessment and intervention guidelines[1,2,45] and supported by a health systems approach.[8-10] VIP continues to be aligned to government initiatives to reduce child abuse and neglect and intimate partner violence.

Many developments have occurred within DHBs to support an improved response to family violence. DHBs recently updated policies and training aligned to the 2016 'Family Violence Assessment and Intervention Guideline: Child Abuse and Intimate Partner Violence'.[2] In 2018, all 20 DHBs achieved the maximum score for Delphi tool 'policies & procedures' and 'documentation'. Introduction of DHB senior leadership, ownership and accountability for the VIP as the weightiest domain of the revised Delphi tool is consistent with evidence that organisational climate for innovation is a predictor of family violence service delivery.[46] Clinical Snapshot data evidences that best practice is possible, with some (16%) service locations achieving the target assessment and disclosure or concern rates.

Other evaluation findings, however, indicate that performance has not reached the level indicative of a learning system. The Delphi tool domains 'quality improvement' and 'VIP practices' point to insufficient progress in applying the Model for Improvement[12] and in delivering a consistent quality service. Indeed, only 12 DHBs (60%) reported having 'a regular formal process whereby the VIP evaluation and quality improvement findings are discussed, reviewed and acted on with respective services'. The majority of service locations (84%) have not achieved target assessment and disclosure or concern rates, with significant system variation. Understanding the "causes underlying the differences and determining what actions may be appropriate to take to improve health outcomes"[47] remains a challenge. There are likely many reasons why barriers to the Violence Intervention Programme's full and sustainable integration into practice remain. Monitoring service delivery continues to be challenging in itself. Most DHB programmes are dependent on paper files for their data monitoring, making it a time-consuming process. Standardised digitalisation of family violence indicators would increase efficiency and promote shifting effort from monitoring to providing time for developing 'stronger feedback loops' called for by Braithwaite[48] and consistent with the Model for Improvement.[12] There is a call for a move away from relying on more top down policies to 'stronger feedback loops to nudge system behaviour out of equilibrium, thereby building momentum for change' (p.1).[48]

The response to family violence is not a tick box affair. It demands a supportive system with a skilled workforce sensitive to the dynamics of family violence, including the entanglement between intimate partner violence and child abuse and neglect and the family harm caused by a pattern of coercive and controlling behaviours.[49-51] This is essential if we are to meet our obligation to prevent and reduce the harm of family violence, particularly for Māori.[52] The Violence Intervention Programme is continuing to evolve, informed by infrastructure and practice-based evidence, to meet this challenge.

EVALUATION STRENGTHS AND LIMITATIONS

Strengths of this evaluation project include using established family violence programme evaluation instruments and following standard quality improvement processes in auditing.[12,53] 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.[8]

The audit rounds foster a sense of urgency,[54] supporting timely policy revisions, procedure endorsements and FVI Coordinator position vacancies. Finally, and perhaps most importantly, the longitudinal nature of the evaluation has allowed monitoring of change over time. The addition of clinical Snapshot audits in 2014 provides standardised data aggregated across DHBs for accountability and performance measurement.

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

Limitations are important to consider in interpreting the findings and making recommendations based on this evaluation work. By design, this study is limited to DHBs providing acute hospital and community services at

secondary and tertiary public hospitals. The VIP does not include services provided by private hospitals, which may also provide publicly funded services, or primary care where family violence prevention programmes are being introduced opportunistically in DHB regions. Current VIP programme limitations are also carried over to this evaluation, for example, neither the Ministry of Health Guideline, nor this evaluation work, addresses the health response to those who have a pattern of using controlling, coercive behaviours.

In this first application of the revised Delphi audit, the self-report method likely introduced some error. We noted, for example, when both external- and internal- audits were conducted in past evaluations, there was a pattern of over-reporting by DHBs. For this first self-administration of the Delphi revised tool, for example, we noted that among the 20 DHBs, 17 (85%) correctly reported the Delphi training item 2.2 (core training observation within 2 years). Three DHBs over-reported having had a training observation. The 'true' proportion that met the indicator, therefore was 70% (11/20) rather than 85%. The DHBs 'over-reporting' had received a 'training induction' visit during the period, but not a training observation (with accompanying feedback). Ideally, external audits would occur as they would reduce error and provide a strengths-based positive team approach to improvement.

While the clinical Snapshot audits are important to monitor service delivery, there are important limitations to be aware of. These include the following.

- The Snapshot audit does not capture all recommended family violence assessment and intervention, such as for male patients presenting with signs or symptoms indicative of abuse or services provided in the primary care setting.
- The Snapshot sample size for individual DHBs is small (n=25). For example, a DHB may have assessed for abuse in 15 out of 25 eligible cases (60%) with a single abuse disclosure (1/15, 6.7%), with increasingly wide confidence intervals. Individual DHB estimates are therefore considered only indicative of service delivery.
- The Snapshot audit monitors a limited number of service delivery indicators, sensitive to the burden of manual medical record review. Not captured, for example, is the graduated health response based on assessed level of risk.

Finally, across the evaluation methods there is insufficient resource addressing information on the experience of service users, particularly for Māori. While gathering the lived experience requires sensitivity, it is critical to understand people's journey through the health system[55] as they seek assistance supporting safety and wellbeing for themselves and their children and whānau or family.

VIP PRIORITIES

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

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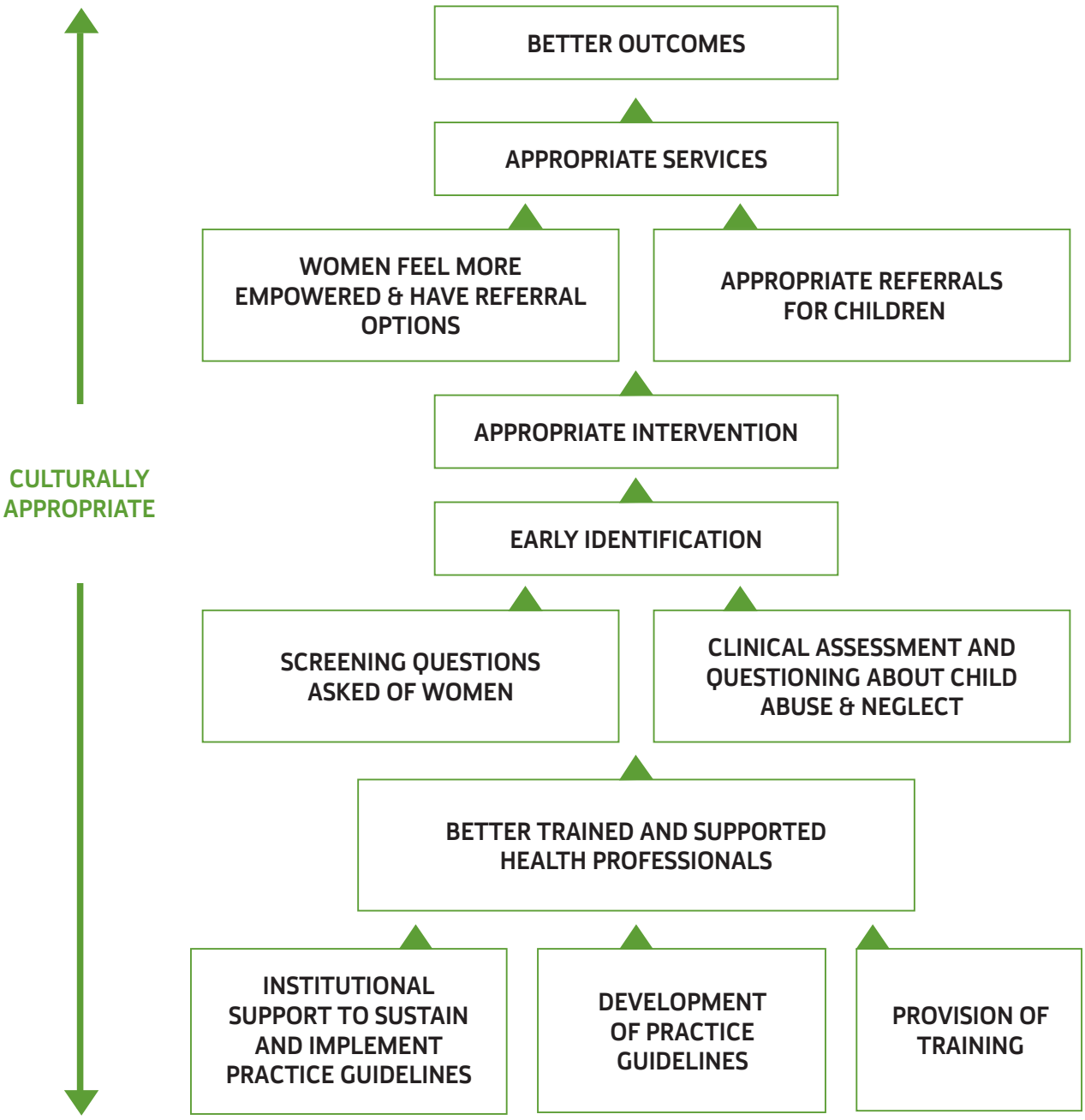
APPENDICES

APPENDIX A: FAMILY VIOLENCE PROGRAMME LOGIC



Family Violence Programme Logic
MOH Advisory Committee; modified from Duignan, Version 4, 16-10-02

APPENDIX B: DISTRICT HEALTH BOARD HOSPITALS

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

S = secondary service, T = tertiary

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

APPENDIX C: VIP EVALUATION INFORMATION PACK FOR DHBS (2018)

CENTRE FOR INTERDISCIPLINARY TRAUMA RESEARCH
AUT UNIVERSITY

VIP violence intervention programme

VIP EVALUTION INFORMATION PACK 2018

1

Table of Contents

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 2018.

The 2018 VIP evaluation includes:

Evaluation Activity	Audit period	Measuring	Tool	How to submit	Due date
VIP Delphi self-audit	1 July 2017 – 30 June 2018	System infrastructure	Revised Delphi Self-Audit Tool (Excel workbook to be completed)	Email completed tool to Arlene Advani	30 September 2018
VIP Snapshot clinical audits	1 April 2018 – 30 June 2018	Accountability	Random sample of 25 records in 7 services (VIP Snapshot website)	Completed on-line Snapshot	30 September 2018
PDSA's	On-going	Quality improvement	Two PDSA worksheets – emailed to audit team to review	Email worksheets to Arlene Advani	30 September 2018 (PLAN only) 10 December 2018 (completed PDSA worksheets)

This document outlines each activity in more detail.

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 2018 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. For 2018, DHBs will not be named on the revised Delphi self-audit tables or charts when presented to the group or published in a national report.
- Evaluators are available to attend regional FVIC meetings if required to present and discuss 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:

- Moira Howson for evaluation queries. Moira is available Mondays and Fridays from 9am to 3pm. You can reach her on Moira.howson@aut.ac.nz or 021 707-392.
- 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
- 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

Arlene Advani Administrator Centre for Interdisciplinary Trauma Research School of Clinical Sciences Auckland University of Technology (09) 921 9999 x7153 aadvanni@aut.ac.nz	Moira Howson Research Officer Centre for Interdisciplinary Trauma Research School of Clinical Sciences Auckland University of Technology (021) 707 392 moira.howson@aut.ac.nz	Professor Jane Koziol-McLain, PhD, RN Principle Investigator Centre for Interdisciplinary Trauma Research School of Clinical Sciences Auckland University of Technology (09) 921 9670 jkoziolm@aut.ac.nz

2. 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 revised Delphi self-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 revised 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.

3. The revised VIP Delphi self-audit

Please complete the **revised VIP Delphi Tool** and **do not** complete the 'old' VIP Delphi Tools for Partner Abuse and Child Abuse and Neglect.

The **revised VIP Delphi self-audit tool** covers the one-year period 1 July 2017 to 30 June 2018. It replaces the VIP Delphi tools for partner abuse/intimate partner violence (IPV) and child abuse and neglect (CAN). In this section we:

- Answer frequently asked questions (FAQs) on the revised 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 revised Delphi self-audit

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. **Why did we revise the Delphi tools?**
    a. There is a "ceiling effect" whereby since 2011 most DHBs have scored in the high 90s clearly exceeding the '80' benchmark. Therefore:
        i. The results are not providing DHBs and the Ministry of Health information on where to focus efforts for programme development
        ii. We cannot measure further progress as the scores cannot move much higher
        iii. There may be less impetus for DHB leadership to support change and invest in programme infrastructure enhancements if the benchmark is consistently met.
    b. The current tools have over 300 items and are burdensome for staff to complete.
    c. In 2016 the Ministry of Health Family Violence Assessment and Intervention Guideline (MOHVAIG) was released, requiring updating language and expected procedures.

3. **What is the aim of the new 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 new benchmark for DHBs to measure themselves against.

4. **What is different in the new tool?**
    a. It is shorter, combining the IPV and CAN audits into one tool with 9 domains and a total of 56 main items.
    b. There are new domains including Organisational Leadership, Cultural Responsiveness and Resource Funding.
    c. Some domains and items on the new tool should be completed by a **Senior DHB Manager** with responsibility for the family VIP within each DHB. (These items are clearly highlighted in the audit tool and further in the information pack).

5. **What support will DHBs receive from the external auditor?**
    a. In 2018, phone support will be available through AUT's Centre for Interdisciplinary Trauma Research. You can contact Moira Howson on 021 707-392 or at moira.howson@aut.ac.nz who will be able to provide you with help on the new tool. She is available Monday and Friday 9am to 3pm.
    b. Evaluators are available to attend regional VIP Coordinator meetings.
    c. Funding for external site visits for future audits from 2019 is being reviewed.

6. **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.

7. **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.

8. **What will my score look like in the new system?**
    a. Pilot testing indicates that most DHBs who have been scoring in the high 90s are likely to score in the 60s or 70s due to the aspirational nature of the tool.
    b. In the first round with the new tool (2017-2018), DHB scores will not be named in national reports.
    c. Based on the findings of the first round, a new benchmark will be set for DHB VIPs to aim for.
    d. 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.

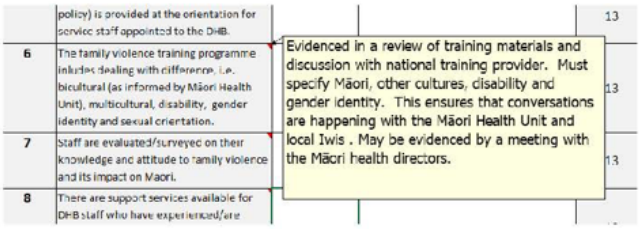
3.2 How to gather evidence for the revised Delphi self-audit?

3.2.1 What evidence is required?

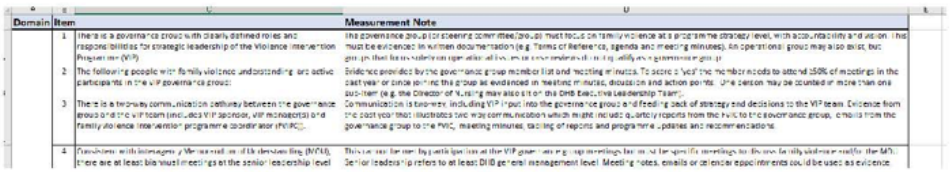
Evidence is required to support scoring throughout the Delphi self- audit tool. As you read through the audit tool items and measurement notes, you will be able to identify what evidence is needed.

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



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 revised 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 revised Delphi self-audit?

The Delphi self-audit tool is an excel macro enabled worksheet which will be emailed to you by the AUT evaluation team. It is also accessible on our family violence project evaluation family violence project evaluation web-site (www.aut.ac/vipevaluation)The following may help you:

- 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 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 30 September 2018.

4. VIP Snapshot clinical audit 2018

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 medical records as soon as possible of the audit requirements for each of the 7 services (specified below). The requirements are retrospective random samples of 25 patient health records selected from the 3-month review period – 1 April to 30 June 2018.

4.1.1 Included services

Seven DHB services are to be included in the 2018 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 2018 to 30 June 2018**.

4.1.4 Due date

The audit data should be entered by **30 September 2018.**

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 2018) 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'.

4.2.3 Definitions

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

4.2.4 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**.

4.2.5 Starting a new 2018 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'.

4.2.7 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 2019 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	• 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'

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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'.

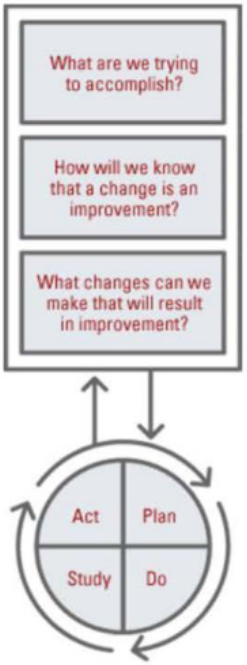
CAN Consultation

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.

5. PDSA

Plan-Do-Study-Act

5.1 Overview



The objectives of your PDSAs should be to improve your Snapshot results. This means improving the IPV routine enquiry, disclosure and referral and/or the CAN assessment, reports of concern and consultation rates in one or two of the Ministry of Health's designated VIP services within your DHB that you completed the Snapshot audits on.

The PDSA method is a way to test a change that is implemented. By going through four steps it guides the thinking process into separate steps including evaluating the outcome, improving on it and testing it again. 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 2018 PDSA due dates are:

- **30 September**: Submit two PDSA worksheets with only the PLAN required at this time.
- **14 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 2018 evaluation information and there is also a copy at the back of this document.

5.4.1 Title and cycle

- The **title** should state 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 30 September)

- 'I Plan to':
  - Write a concise statement of what you plan to do in this cycle of testing. It should be small and focused.
- "I hope this produces':
  - Here you can put a measurement or an outcome that you hope to achieve. 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.
- Data
  - Detail what data is needed to test your predictions and 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 implementation 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?

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VIP violence intervention programme

5.5 PDSA cycle worksheet

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

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**

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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?	

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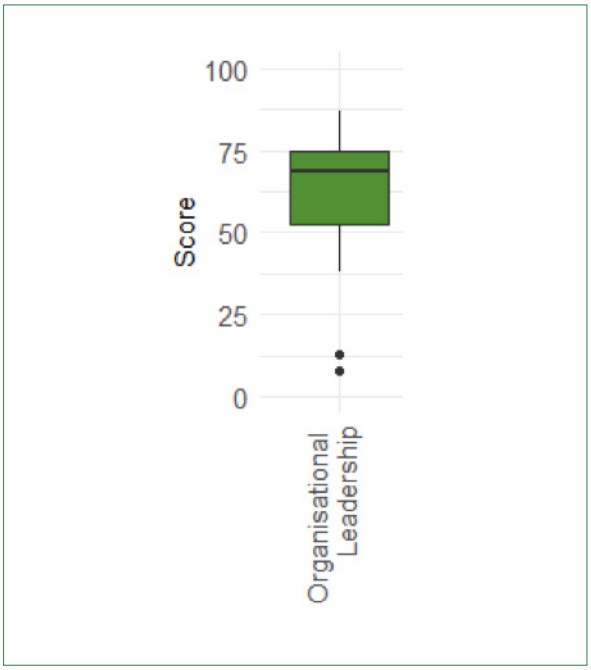
6. References to assist you

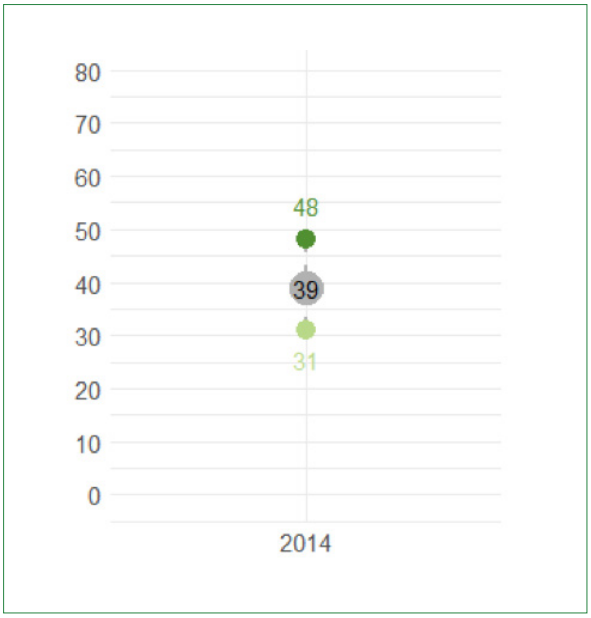
- Fanslow J L, Kelly P, Ministry of Health. 2016. Family Violence Assessment and Intervention Guideline: Child abuse and intimate partner violence (2nd edn). Wellington: Ministry of Health.
- Langley, G. J., Moen, R. D., Nolan, K. M., Nolan, T.W., Norman, C. L. & Provost, L. P. (2009). The improvement 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

Item	Domain	Response (Yes)
1	**Organisational Leadership**	
1.1	There is a governance group with clearly defined roles and responsibilities for strategic leadership of the Violence Intervention Programme (VIP).	17 (85%)
1.2	The following people with family violence understanding are active participants in the VIP governance group:	
1.2.1	*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%)
1.2.2	*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%)
1.2.3	*At least one **directorate leader** (or equivalent) from **corporate services** (e.g. Quality and Risk, Funding & Planning).*	11 (55%)
1.2.4	*A **Māori leader** within the DHB or community.*	15 (75%)
1.2.5	***Senior manager(s)*** responsible for services implementing VIP.	17 (85%)
1.2.6	***VIP team member*** (sponsor, manager or coordinator).	18 (90%)
1.3	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%)
1.4	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.	
	(i) Neither	7 (35%)
	(ii) Oranga Tamariki or Police	2 (10%)
	(iii) Both	11 (55%)
1.5	**Executive** leadership of VIP demonstrated by:	
1.5.1	*District Annual Plan/Strategic Plan specifies VIP.*	14 (70%)
1.5.2	*VIP status reporting to the DHB Board at least annually.*	10 (50%)
1.5.3	*Quarterly agenda item for DHB Board or a designated Advisory Committee to the Board regarding VIP contract deliverables and KPIs.*	7 (35%)
1.5.4	*Current, endorsed DHB policy that includes compulsory 8-hour VIP core training for all clinical staff in designated services.*	20 (100%)
1.5.5	*Implementing and monitoring the key performance indicators (KPIs) reporting by services.*	10 (50%)
1.5.6	*Evidence of acting on non-attained KPI(s), noting recommendations for improvement, necessary resourcing and follow up.*	8 (40%)
1.6	**Senior clinical leaders** communicate the expected VIP standard of clinical practice to their professional group(s)	
1.6.1	Clinical Director (Chief Medical Officer)	8 (40%)
1.6.2	Director of Nursing	8 (40%)
1.6.3	Director of Midwifery	13 (65%)
1.6.4	Director of Allied Health	11 (55%)

Item	Domain	Response (Yes)
1	**Organisational Leadership (Continued)**	
1.7	Service Leaders report on the following key performance indicators (KPIs) to their senior managers at least quarterly.	
1.7.1	*How many of the services report on the proportion of staff trained in VIP? (Average)*	2.3
1.7.2	*How many of the services report on the number of VIP clinical champions? (Average)*	2.45
1.7.3	*How many of the services report on assessment and intervention compliance with policy? (Average)*	1.25
1.7.4	*How many of the services report on actions taken to address any non-compliance? (Average)*	1.3
1.8	The implications of DHB initiatives on VIP service delivery where relevant are considered (e.g. design, documentation forms, alert systems).	16 (80%)
1.9	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%)
2	**Training & Support**	
2.1	The DHB VIP core training package and any updates have been signed off by the national training provider.	20 (100%)
2.2	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%)
2.3	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%)
2.4	Follow-up support occurs within one week of training.	12 (60%)
2.5	Information about the VIP (including DHB policy) is provided at the orientation for service staff appointed to the DHB.	16 (80%)
2.6	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%)
2.7	Staff are evaluated/surveyed on their knowledge and attitude to family violence and its impact on Māori.	15 (75%)
2.8	There are support services available for DHB staff who have experienced/are experiencing family violence (including perpetrator and victim)	19 (95%)
3	**Resource Funding**	
3.1	The DHB funding and any extra funding for VIP is spent on the programme and not diverted elsewhere.	20 (100%)
3.1.1	*There is extra funding provided for people and resources specifically to reduce the impact of family violence on Māori.*	7 (35%)
3.1.2	*There is allocated administrative resources and support for the VIP.*	15 (75%)
3.2	*The family violence intervention programme coordinator (FVIPC) roles for IPV and CAN are currently filled.*	
	(i) None	0 (0%)
	(ii) IPV or CAN	2 (10%)
	(iii) BOTH	18 (90%)
3.2.1	*How many months in the past 12 months has the coordinator role been filled? (Average)*	0.95

Item	Domain	Response (Yes)
4	**VIP Practices**	
4.1	At least 80% of women receive routine inquiry for IPV in each designated service.	1 (5%)
4.2	At least 5% of women who receive a routine inquiry disclose IPV in each designated service	4 (20%)
4.3	All women who disclose IPV are offered a referral to a specialised service or agency.	14 (70%)
4.4	A Child Protection Checklist is completed for at least 95% children under the age of two presenting in an Emergency Department.	3 (15%)
4.5	There is evidence of consultation with someone who has child protection specialist knowledge for all cases when child protection concerns are identified.	14 (70%)
4.6	For all Reports of Concern (ROC) made to Oranga Tamariki, child protection concerns are identified, and safety plans are documented.	12 (60%)
4.7	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%)
5	**Cultural Responsiveness**	
5.1	Knowledge of family violence dynamics that address personal and whānau needs for specific groups are embedded in the VIP policy:	
5.1.1	*Māori*	20 (100%)
5.1.2	*Other cultures*	20 (100%)
5.1.3	*Disabled*	16 (80%)
5.1.4	*Gender identity*	17 (85%)
5.2	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.	
5.2.1	*Cultural competency of the service is evident in VIP policy.*	19 (95%)
5.2.2	*Cultural competency is included in VIP training.*	19 (95%)
5.2.3	*Cultural competency of staff is assessed through staff surveys of attitudes and understanding or family violence and its impact for Māori.*	11 (55%)
5.2.4	*Feedback is sought from Māori who interact with the VIP service that specifically addresses the cultural responsiveness of the service.*	6 (30%)
5.3	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%)
5.4	There are culturally inclusive family violence pathways and services available in the community.	20 (100%)
5.5	The delivery of the service for Māori is evaluated by Māori in a way that is culturally appropriate and safe.	
	(i) No	13 (65%)
	(ii) Yes	6 (30%)
	(iii) Yes Māori led	1 (5%)
5.6	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%)
5.7	Information is available, relevant, and on display in Te Reo.	16 (80%)
5.7.1	*Information is available or on display in other languages (not including English) that reflects the DHB's catchment demographic if needed.*	12 (60%)

Item	Domain	Response (Yes)
6	**Quality Improvement**	
6.1	VIP is included in the DHB quality and risk strategic plan.	6 (30%)
6.2	There is a formal VIP quality improvement plan.	11 (55%)
6.3	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%)
6.4	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%)
6.5	Evaluation includes health care providers receiving feedback relevant to their involvement with the VIP.	18 (90%)
6.6	Patient/client or community agency feedback regarding VIP service delivery is gathered and analysed on a regular basis (at least annually).	7 (35%)
6.7	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%)
6.8	**A Māori quality framework (such as Whānau Ora) is used by DHB leadership to evaluate whether services are effective for Māori.**	6 (30%)
6.8.1	*This process includes Māori Health Unit review of feedback and recommendations for improving the VIP effectiveness for Māori.*	6 (30%)
6.9	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%)
7	**Policies & Procedures**	
7.1	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%)
7.2	The DHB family violence policies and procedures are aligned with current legislation and relevant national policy initiatives (e.g. MOUs)	20 (100%)
7.3	The policies and procedures are readily available to staff on the intranet (within 3 clicks).	19 (95%)
7.4	The Māori Health Unit participate in policy review and endorse all DHB family violence policy and procedure.	16 (80%)
7.5	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%)
8	**Collaboration**	
8.1	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:	
8.1.1	*Signing of MOU*	
	(i) Neither	0 (0%)
	(ii) Oranga Tamariki or Police	0 (0%)
	(iii) Both	20 (100%)
8.1.2	*Regular meetings at service level with actions and accountability (at least biannual)*	
	(i) Neither	6 (30%)
	(ii) Oranga Tamariki or Police	2 (10%)
	(iii) Both	12 (60%)

Item	Domain	Response (Yes)
8	**Collaboration *(Continued)***	
8.1.3	*Interagency review of cases*	
	(i) Neither	3 (15%)
	(ii) Oranga Tamariki or Police	3 (15%)
	(iii) Both	14 (70%)
	Participation in or initiation of interagency training	
	(i) Neither	3 (15%)
	(ii) Oranga Tamariki or Police	2 (10%)
	(iii) Both	15 (75%)
8.2	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%)
8.3	Ongoing partnership between the DHB and Māori service agencies or health providers, and/or local Iwi or Urban Māori Authority evidenced by:	
8.3.1	*Participation in, or initiation, of training (e.g. involvement in the VIP training at the DHB)*	
	(i) None	5 (25%)
	(ii) 1 Agency	5 (25%)
	(iii) 2+ Agencies	10 (50%)
8.3.2	*Policy review*	
	(i) None	8 (40%)
	(ii) 1 Agency	4 (20%)
	(iii) 2+ Agencies	8 (40%)
	Representation on the VIP governance group	
	(i) None	6 (30%)
	(ii) 1 Agency	5 (25%)
	(iii) 2+ Agencies	9 (45%)
8.4	There is evidence of engagement and collaboration with external family violence services agencies at a senior management and operational VIP level.	
8.4.1	*Senior management level (provide examples)*	17 (85%)
8.4.2	*Operational VIP level (provide examples)*	18 (90%)
8.5	There is an MOU or SLA with the following agencies regarding the service delivery for victims of sexual assault (adults, adolescents and children).	
8.5.1	*Police*	18 (90%)
8.5.2	*ACC*	16 (80%)
8.5.3	*Oranga Tamariki*	15 (75%)
8.5.4	*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%)

Item	Domain	Response (Yes)
8	**Collaboration *(Continued)***	
8.6	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.	
8.6.1	*At least 1 review for IPV?*	11 (55%)
8.6.2	*At least 1 review for CAN?*	15 (75%)
9	**Documentation**	
9.1	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%)
9.1.1	*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%)
9.2	The national form (Report of Concern) is used for referral to Oranga Tamariki	20 (100%)
9.3	Patients with injuries caused by family violence are routinely offered a medical photography option, either in the DHB or by the police.	16 (80%)

APPENDIX G. IPV SERVICE POPULATION ESTIMATES

Population estimates of women who received intimate partner violence assessment and specialist intimate partner violence by service (April – June, 2014–2018)

	Women assessed					Disclosures					Referrals*				
Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2014**	**2015**	**2016**	**2017**	**2018**	**2014**	**2015**	**2016**	**2017**	**2018**
Postnatal Maternity Inpatient															
Weighted Mean (95% CI)	33% (26, 39)	48% (42, 55)	52% (46, 58)	53% (49, 57)	62% (57, 68)	9% (3, 14)	4% (2, 6)	3% (2, 4)	4% (3, 6)	3% (1, 4)	75% *	100% *	83% *	60% *	82% *
Population estimate (95% CI)	2935	4637 (4,033/ 5,241)	4954 (4,374/ 5,533)	5965 (5,484/ 6,446)	7531 (6,870/ 8,193)	257	197 (114, 280)	138 (79, 197)	264 (156, 373)	191 (109, 272)	193 *	197 *	125 *	232 *	169 *
Child Health Inpatient															
Weighted Mean (95% CI)	39% (31, 48)	35% (33, 38	42% (36, 48)	39% (36, 43)	43% (39, 48)	6% (4, 9)	4% (2, 5)	4% (2, 5)	7% (5, 9)	11% (7, 15)	70% *	100% *	75% *	69% *	72% *
Population estimate (95% CI	4869	4513 (4,180/ 4,847)	5180 (4,423/ 5,937)	5118 (4,640/ 5,595)	4655 (4,163/ 5,146)	259	160 (83, 237	193 (116, 271)	339 (237, 441)	505 (327, 683)	181 *	160 *	125 *	255 *	366 *
Sexual Health															
Weighted Mean (95% CI)	N/A	48% (42, 55)	54% (44, 63	67% (56, 79)	69% (53, 85)	N/A	20% (13, 27)	15% (11, 19)	19% (11, 26)	10% (7, 13)	N/A	83% *	69% *	55% *	58% *
Population estimate (95% CI)		2703 (2,330/ 3,076)	3917 (3,243/ 4,591)	4643 (3,835/ 5,450)	5298 (4,076/ 6,520)		537 (349, 725)	589 (437, 742)	860 (500, 1220)	530 (366, 693)		446 *	388 *	627 *	425 *
Emergency Department															
Weighted Mean (95% CI)	N/A	23% (20, 26)	27% (24, 29)	30% (26, 34)	32% (27, 37)	N/A	6% (4, 8)	14% (11, 18)	12% (9, 15	22% (14, 31	N/A	75% *	94% *	78% *	88% *
Population estimate (95% CI)		21924 (18,819/ 25,029)	25758 (22,887/ 28,628)	30330 (26,418/ 34,243)	34314 (28,665/ 39,963)		1310 (917, 1702)	3568 (2806, 4510)	3544 (2639, 4448)	7677 (4736, 10617		982 *	3581 *	2418 *	7031 *

	Women assessed					Disclosures					Referrals*				
Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2014**	**2015**	**2016**	**2017**	**2018**	**2014**	**2015**	**2016**	**2017**	**2018**
Postnatal Maternity Inpatient															
Weighted Mean (95% CI)	N/A	N/A	52% (38, 67)	61% (47, 76)	53% (43, 62)	N/A	N/A	34% (25, 44)	27% (19, 35)	30% (23, 37)	N/A	N/A	59% *	88% *	87% *
Population estimate (95% CI)			829 (602, 1055)	894 (688, 1100)	1358 (1110, 1606)			285 (205, 365)	239 (168, 311)	410 (316, 504)			152 *	175 *	350 *
Child Health Inpatient															
Weighted Mean (95% CI)	N/A	N/A	52% (43, 62)	40% (32, 48)	44% (36, 51)	N/A	N/A	24% (19, 29)	28% (22, 34)	20% (17, 23)	N/A	N/A	64% *	90% *	82% *
Population estimate (95% CI			1769 (1,444/ 2,095)	2369 (1,977/ 2,987)	2878 (2,366/ 3,391)			422 (334, 511)	661 (538, 839	576 (483, 669)			257 *	597 *	394 *

Notes: Proportion of IPV disclosures is among those who were assessed for IPV; proportion of IPV referrals is among those who disclosed IPV; confidence intervals not calculated for referrals due to small numbers within individual DHBs. VIP rollout across services spanned 2014 – 2016.

Population estimates for referral by type (active/passive)

Year	2014	2015	2016	2017	2018
Postnatal Maternity Inpatient					
Active	193 (75%)	99 (50%)	112 (90%)	193 (83%)	113 (67%)
Passive		98 (50%)	13 (10%)	39 (17%)	56 (33%)
Child Health Inpatient					
Active	181 (70%)	107 (67%)	104 (83%)	185 (73%)	225 (61%)
Passive		53 (33%)	21(17%)	69 (27%)	141 (38%)
Sexual Health					
Active	N/A	81 (21%)	123 (32%)	199 (32%)	202 (48%)
Passive		296 (79%)	265 (68%)	427 (68%)	223 (52%)
Emergency Department					
Active	N/A	592 (50%)	2528 (71%)	1209 (50%)	5433 (77%)
Passive		591 (50%)	1053 (29%)	1209 (50%)	1598 (23%)
Alcohol and Drug – new female clients presenting to service					
Active	N/A	N/A	76 (50%)	75 (43%)	165 (57%)
Passive			76 (50%)	100 (57%)	127 (44%)
Community Mental Health – new female clients presenting to service					
Active	N/A	N/A	171 (67%)	358 (60%)	289 (73%)
Passive			86 (33%)	239 (40%)	105 (27%)

Notes: 2017 referral type data updated from earlier reports with quality file checks.

APPENDIX H. DHB SERVICES ACHIEVING ASSESSMENT & IDENTIFICATION TARGET RATES (2018)

	Bay of Plenty	Canterbury	Counties Manukau	Hutt Valley	Mid Central	South Canterbury	Southern	Tairawhiti	Taranaki	West Coast	Whanganui	Total
Intimate Partner Violence (n=18) | Target: Assessment ≥ 80% and Disclosure ≥ 5%												
Postnatal Maternity												0
Child Health Inpatient												2
Sexual Health												8
Emergency Department												1
Community Mental Health												3
Community Alcohol & Drugs												4
Child Abuse & Neglect (n=2) | Target: Assessment ≥ 80% and Concern ≥ 5%												
Emergency Department												2

Notes:

Near Target: Assessment ≥ 70% & Concern/Disclosure ≥ 3%

Achieved Target

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

Child abuse and neglect assessment rates by ethnicity for children under two years of age presenting to the emergency department (April–June quarter, 2014–2018)

CAN Assessment	2014		2015		2016		2017		2018	
	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori
CAN Assessment/ Reviewed	72/391 18%	50/175 29%	107/392 27% (23%, 32%)	45/183 25% (18%, 31%)	103/401 26% (21%, 30%)	24/150 16% (11%, 42%)	54/168 32% (25%, 40%)	54/168 32% (25%, 40%)	164/344 48% (42%, 53%)	60/158 38% (30%, 46%)

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

IPV Routine Enquiry	2014		2015		2016		2017		2018	
	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori
Postnatal Maternity	160/429 37%	53/120 44%	229/439 52% (47%, 57%)	60/137 44% (35%, 52%)	238/433 55% (50%, 60%)	67/120 56% (47%, 65%)	243/434 56% (51%, 61%)	55/110 50% (41%, 59%)	257/416 62% (57%, 66%)	68/111 61% (52%, 70%)
Child Health Inpatients	266/429 37%	110/336 33%	142/374 38% (33%, 43%)	73/169 43% (36%, 51%)	154/377 46% (41%, 52%)	52/149 40% (31%, 49%)	151/377 40% (35%, 45%)	57/147 39% (31%, 49%)	160/356 45% (40%, 50%)	80/145 55% (47%, 63%)
Emergency Department	N/A	N/A	118/447 26% (22%, 31%)	26/104 25% (17%, 33%)	117/408 29% (24%, 33%)	26/93 28% (19%, 37%)	135/410 33% (28%, 37%)	27/88 31% (21%, 41%)	108/383 28% (24%, 33%)	41/117 35% (26%, 44%)
Sexual Health	N/A	N/A	164/277 59% (53%, 65%)	69/101 68% (59%, 78%)	172/262 66% (60%, 71%)	43/79 54% (43%, 66%)	202/275 73% (68%, 79%)	60/89 67% (57%, 77%)	207/272 76% (71%, 81%)	41/117 35% (26%, 44%)
Alcohol & Drug	N/A	N/A	N/A	N/A	96/199 50% (43%, 57%)	46/101 46% (36%, 55%)	143/257 56% (50%, 62%)	52/81 64% (54%, 75%)	155/235 57% (47%, 66%)	65/115 66% (60%, 72%)
Community Mental Health	N/A	N/A	N/A	N/A	144/302 48% (42%, 53%)	41/87 47% (36%, 58%)	164/345 48% (42%, 53%)	49/122 40% (31%, 49%)	214/369 58% (53%, 63%)	32/99 32% (23%, 42%)

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