The System Audit Family Violence Evaluation (SAFE) Project

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The System Audit Family Violence Evaluation (SAFE) Project

Final Report | November 2021

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Collier
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Fund

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Finally, we acknowledge those staff across multiple hospitals, health services, key organisations and government departments who contributed via survey and workshop participation to the development of the SAFE Tool.

“

Thanks to [the] RWH [Royal Women’s Hospital] and [the] University of Melbourne for their commitment to evaluate family violence capacity building strategies and efforts within the health service environment. It provides health services the opportunity to track their efforts into the future (provided appropriate motivation and associated resources) by the embedding and use of the audit tool. It should not be just up to each health service to continue this work off their own bat, it requires systemic embedding and resourcing by the State Government (similar to the NZ model).

”

(SAFE Site Survey participant)

Executive Summary

The Victorian State Government has made a significant investment to support public hospitals and health services implement the Strengthening Hospital Responses to Family Violence (SHRFV) program, which provides a whole-of-organisation approach. This SHRFV model, implementing system change to address family violence, is the major part of current family violence program of work in health services.

There has been minimal funding for evaluation of the SHRFV program. There is also a need to develop an evidence base for how change is occurring in health settings to inform policy and practice across Victoria and Australia. The System Audit Family Violence Evaluation (SAFE) Project addresses this gap by implementing a research initiative using a purpose designed System Audit Tool (SAFE Tool) administered at eighteen Victorian health services to evaluate the impact of the SHRFV program.

Method

- The SAFE Project was launched at the Women's International Women's Day Breakfast in March 2019.
- The eighteen diverse health services administered the system audit SAFE Tool in three stages from November 2019 to April 2021.

The SAFE Tool

The SAFE Tool provides an Overall Score derived from individual scores weighted across ten domains:

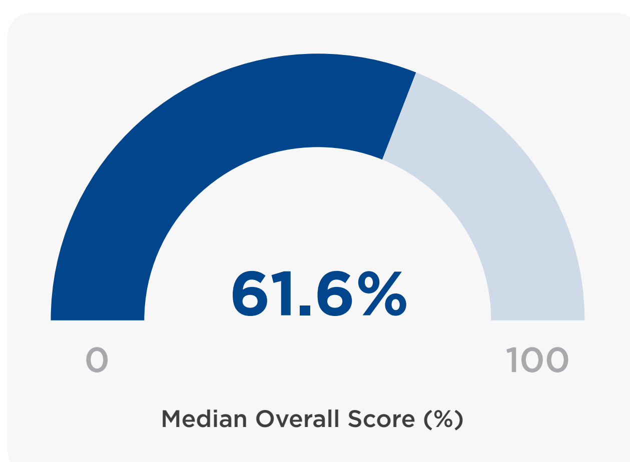
- one Patient Domain focussed on identification and response to patients (13 indicators)
- two Staff Domains focussed on staff support and training to undertake the work (13 indicators)
- seven Organisational Domains focussed on system factors needed to support staff including: policies, procedures and guidelines; governance and leadership; intersectionality and diversity; collaboration; infrastructure; culture; and quality improvement (45 indicators).

The SAFE Tool and participating in the SAFE Project has provided a detailed picture of where the health service has made positive progress, in addition to areas of further improvement.

(SAFE Site Survey participant)

Findings in context

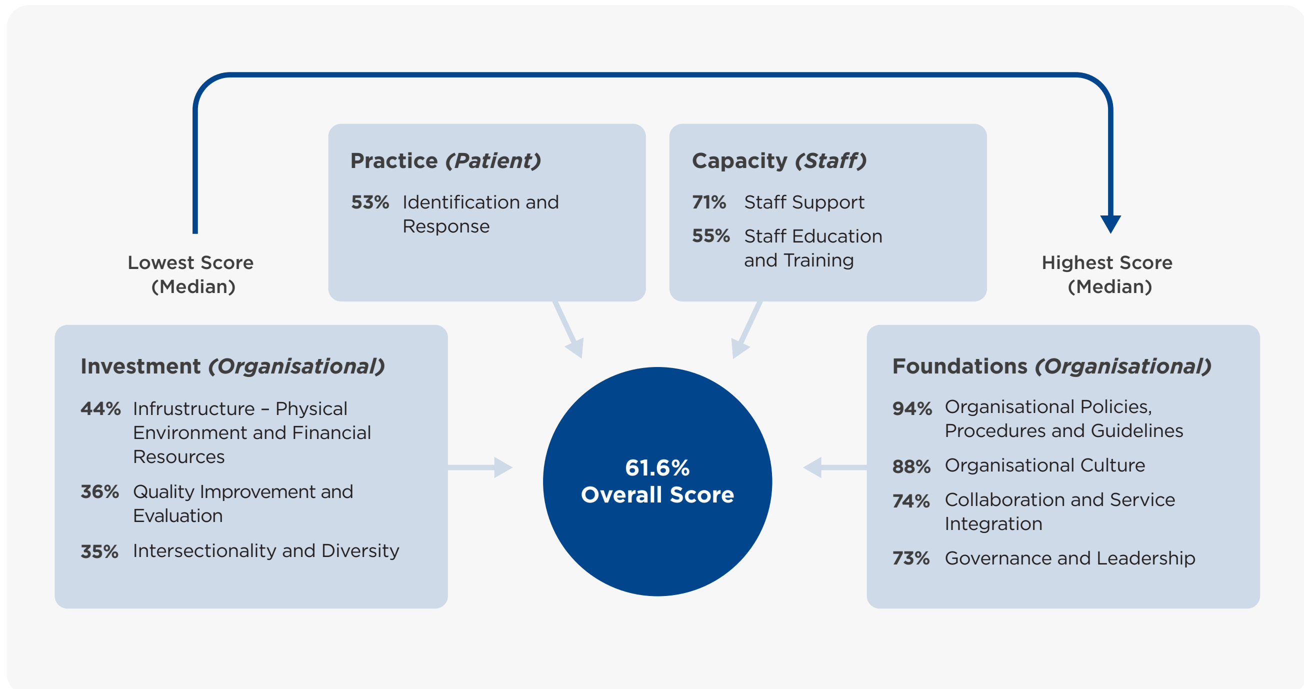
Overall Scores



- Overall Scores ranged between 50.8% and 79.6%. The median (middle) was 61.6%.
- There was general consistency across the SAFE Sites - three sites scored very well, none were outstanding, neither was any site significantly lower than the rest.
- Results suggest that while the health services have systems in place to respond to family violence, there continues to be a need for further resourcing and improvement in a range of domains at all participating sites.

Domain Scores

Ranking of SAFE Domains based on median scores from lowest to highest scores



The pattern formed by this ranking of domain performance (based on median (middle) scores) largely aligned with SHRFV program key directions, strategies and resources. Reflective of the SHRFV model the foundations have been laid, staff capacity has started to be built, but it hasn't necessarily translated completely into practice or integrated investment by the health service.

- The four highest performing domains covered the organisational foundations crucial in realising a whole-of-organisation response to family violence.
- Next were the two Staff Domains important in building internal capacity and capability, a necessary step before the practice of patient-centred care could be appropriately undertaken by staff who are supported both professionally and personally in this work.
- The lower ranking of the only Patient Domain indicated the important patient facing work remains an area for development and improvement.
- The three lowest scoring domains covered organisational investment which would help embed the family violence program of work within the health service and facilitate a sustainable and effective family violence program.

The SHRFV program has had a focus on laying the foundations and building capacity for family violence identification and response work through implementing organisational policies and procedures, fostering strong organisational culture, governance and leadership, collaboration and staff support and training. This has been supported through SHRFV resources which are accessible to all. Health services now need to bolster the *patient facing* components of the work, particularly for diverse populations, and invest in the overall family violence program of work moving forward.

These performance audit rankings highlight where sites are doing well and provides a structure for future work and recommendations at the practice level and government level to improve outcomes.

Great initiative and would be great to be involved in a SAFE audit in the future.

(SAFE Site Survey participant)

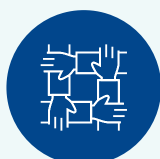
Recommendations

Family violence practice in health services

Recommendations for family violence practice cover the three domain areas in the SAFE Tool (patient, staff and organisational) and mirror the areas needing more attention found by the SAFE Tool.

Greater Investment

- Develop strategies to improve inclusivity and accessibility of the family violence program for diverse groups
- Undertake the SAFE Tool annually to provide quality assurance and feedback mechanisms
- Create safe confidential spaces and strategies across the health service and at home for community teams or telehealth services
- Commit to funding of a family violence role within the health service to ensure the program is sustained

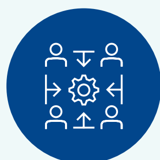


Strengthen Practice

- Develop effective strategies to undertake family violence antenatal screening
- Implement identification, risk assessment and safety planning across all services where patients/clients are at high risk of family violence and ensure this is effectively documented, and information shared with other services
- Develop response to patients/clients who are perpetrators of family violence and a system to support this work

Build Capacity

- Develop strategies to implement and sustain Family Violence Clinical Champions (who support staff responding to family violence) and Contact Officers (who support staff who have experienced family violence) programs along with an evaluation plan
- Continue to build capacity through staff education/training including:
  - increasing reach and exploring options for expanding mandated family violence training where appropriate
  - providing opportunities for ongoing training and developing a mechanism for updating training



Maintain Foundations

- Strong '*Governance and Leadership*' and '*Organisational Policies, Procedures and Guidelines*'
- Activities that promote strong '*Organisational Culture*' concerning family violence and gender equity
- Ensure ongoing '*Collaboration and Service Integration*'

Develop Actions

- Development of a family violence program Action Plan from the SAFE Audit results to strengthen the strategic and continuous monitoring of the health service's response to family violence and inform system change

Government

In recognition of the role government has in ensuring health services maintain and/or improve responses to family violence, the SAFE Project provides recommendations for government directed at both state and national levels.

Victoria

- Fund annual implementation of the SAFE Tool at health services through the University of Melbourne and with associated health service and survivor governance
- Produce annual state-wide reports based on the SAFE Tool results
- Undertake an annual review, by the University of Melbourne, of the family violence Action Plans of each health service (in line with MARAM and Information Sharing)
- Review and change (where appropriate) the SAFE Tool *Indicators* (and corresponding *Measurement notes*) every three years to ensure alignment with policy directions and legislation

Nationally

- Adapt the SAFE Tool for national use
- Implement the national SAFE Tool and process across Australia
- Establish national standards for responding to family violence in health services
- Include family violence in The National Safety and Quality Health Service (NSQHS) Standards

Conclusion

The SAFE Tool, a System Audit Tool, has been successfully implemented across eighteen Victorian health services by the Royal Women's Hospital and the University of Melbourne. We know that auditing and feedback are powerful mechanisms to change behaviour individually and across organisations. The SAFE Project shows where sites are progressing system change within their organisations to address family violence, and highlights the investment needed and the work still to be done to ensure women and families are on a pathway to safety and well-being across Victoria and nationally.

Thanks to support from the Collier Charitable Fund, we now have a validated audit tool which provides a method to achieve change across health systems in the context of family violence.

(SAFE Research Team)

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Introduction

Introduction

The Royal Women's Hospital and the University of Melbourne obtained a grant from the Collier Charitable Fund to undertake a research project to assess the impact of the Strengthening Hospital Responses to Family Violence (SHRFV) program.

The System Audit Family Violence Evaluation (SAFE) Project developed and implemented a System Audit Tool (SAFE Tool) across eighteen health services to build the evidence base for how health services are implementing system change at the patient, staff, and organisational levels to address family violence.

Background and Aim

Family violence has a devastating intergenerational impact on women, children and the broader Australian community. In Australia, one in six women and one in sixteen men report ever experiencing physical and/or sexual violence in an intimate relationship.[1] Children and other family members are also victimised by directly being exposed to violence in the home. Intimate partner violence, the most common form of family violence, results in an estimated annual cost of $21.7 billion to the Australian economy.[2] It also contributes more to the disease burden among Australian women of child bearing age than other well known risk factors (including use of tobacco or illicit drugs, or high cholesterol).[3]

For many people affected by family violence a health professional visit is the first and maybe the only step in accessing support and care. Therefore, the health sector has a crucial part to play in identifying and responding to family violence.[4] International research is clear that a health system approach is needed to effectively identify and respond to family violence at a population level.[5]

In recent years there has been unprecedented family violence investment across a diverse range of sectors throughout Australia. In 2014 the State Government of Victoria funded the Royal Women's Hospital (the Women's) and Bendigo Health to develop and implement a framework for embedding the practice of identifying and responding to family violence in hospitals and health service (health services used to cover both in this report). This first stage of the initiative 'Strengthening Hospital Responses to Family Violence (SHRFV)' outlined a service model guiding a whole of organisation and system-wide approach.[4] The Victorian Royal Commission into Family Violence later recommended this whole-of-hospital model be adopted in all public hospitals (Rec. 95 Royal Commission).[6] Since then the number of health services participating in the SHRFV program has risen incrementally. Fifteen health services participated in 2015-16 (pilot); then in 2017-18, a $38.4 million government investment in a state-wide rollout led to all public health services (88 at the time) becoming involved in the SHRFV program with state-wide coordination roles established to support smaller health services.

To date there has been minimal funding for evaluation of SHRFV, apart from an early Our Watch Report.[7]

There is a need to develop an evidence base for how change can occur in a health setting to inform policy and practice across Victoria and Australia. The System Audit Family Violence Evaluation (SAFE) Project addresses this gap by implementing a robust research initiative using a purpose designed System Audit Tool (SAFE Tool) to evaluate the impact of the SHRFV program.

Strengthening Hospital Responses to Family Violence (SHRFV) Program

SHRFV provides a whole-of-hospital approach to strengthening health services' response to family violence. It aims to support staff both professionally and personally and introduce practices in health services that assist patients affected by family violence to disclose and seek assistance. SHRFV aims to ensure that health professionals have the capacity to recognise indicators of family violence, provide a sensitive response, and offer support and referral as appropriate.[8]

Based on international best practice,[5] the SHRFV Model has evolved since its first iteration, informed by health service experience around implementation, emerging evidence, and alignment to the Multi-Agency Risk Assessment and Management (MARAM) Framework (2018).[8, 9]

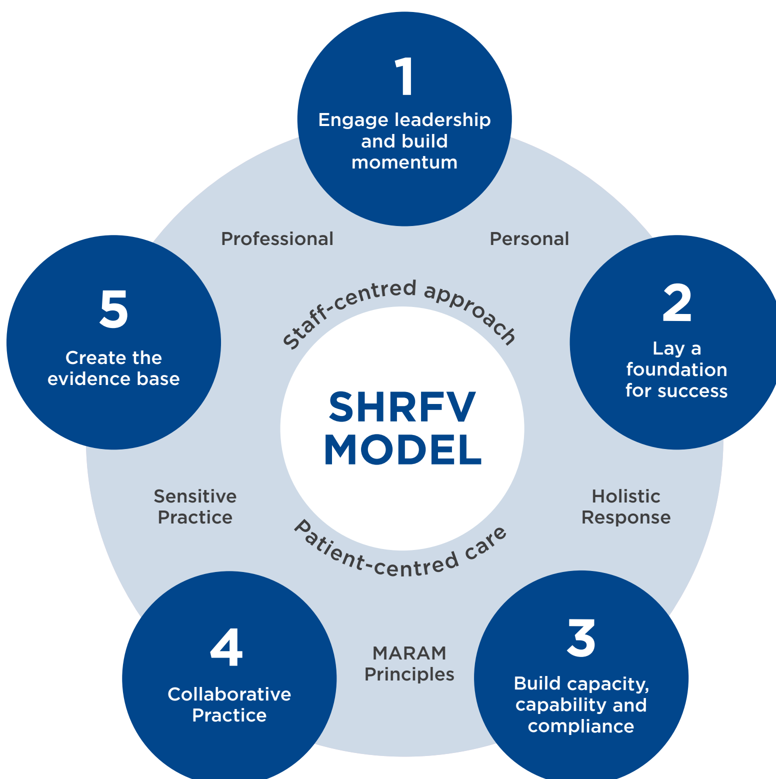
The SHRFV Model (Fifth Edition 2020) comprises two overarching principles, 'Patient-centred care' and 'Staff-centred approach', and five implementation elements (see Figure 1).[8]

MARAM

The Victorian Government's Multi-Agency Risk Assessment and Management (MARAM) Framework articulates a shared responsibility for assessing and managing family violence risk.

MARAM guides *all* services in contact with people and families experiencing family violence and describes best practice for family violence risk assessment and management for services and service workers.[9]

Figure 1: SHRFV program



Source: 'The SHRFV approach: five elements of the approach'.[8 p9]

Element 1 – engaging leadership and building organisation-wide commitment to embed SHRFV and align with the MARAM Framework.

Element 2 – establishing the policies, procedures, guidelines, and infrastructure required to support staff affected by family violence, and health professionals who work to identify and respond to patients affected by family violence.

Element 3 – providing training and development for staff in line with their roles and responsibilities under MARAM with the recommendation that workplace support training be provided prior to commencement of health professional training.

Element 4 – establishing collaborative practice internally, with local family violence services, and the wider community which helps improve outcomes for patients.

Element 5 – evaluating the SHRFV program and MARAM alignment thus contributing to continuous improvement and researching of the model.

The SHRFV program operates within a broader setting and thus implementation and operation of the SHRFV model is affected by a range of factors, including some within the health setting (e.g., size of the health service, range of services provided, level of funding, infrastructure, location) and others outside this environment (e.g., legislation, social attitudes, gender equity norms).

SHRFV DEVELOPMENT

As the SHRFV model has developed, the focus and scope of practice associated with program implementation has changed. Much of this has been in response to the introduction of MARAM which has resulted in a greater emphasis on the ability of all levels of staff to identify and appropriately respond to family violence.[8] Moreover, revisions have ensured the model continues to align with broader Victorian government family violence reforms. Future updates will be required in response to the recently released perpetrator-focused MARAM practice guides (released July 2021)[10] and the expected 2022 release of the MARAM practice guides concerning working with adolescents who use violence in the home.

System Audit Tools and the SAFE Tool

System Audit Tools are a mechanism for whole-of-system evaluation. Such tools have been shown to increase the responsiveness of a health system to victim survivors, and improve family violence identification and response, the culture and environment of a hospital, and resource development.[5] This methodology has been successfully used by the New Zealand Ministry of Health that has funded an annual family violence program evaluation using a system audit tool nationally since 2004.[11] The longitudinal data collected in New Zealand showed a ceiling effect with consistently high audit tool scores from 2011 to 2017, therefore, in 2018 a revised system audit tool was introduced setting new aspirational targets.[12, 13]

In 2019-20 a System Audit Tool (SAFE Tool - a family violence system wide identification and response audit tool) was developed and piloted for use in the Victorian setting with potential for expansion nationally. This work was undertaken at the Royal Women's Hospital (the Women's) in collaboration with the University of Melbourne (also funded by the Collier Charitable Fund).[14]

The SAFE Tool, based on international best practice, is directly informed by the New Zealand Violence Intervention Program (VIP) Evaluation Audit Tool, and developed in consultation with Professor Jane Koziol-McLain (Auckland University of Technology), who has led the design and implementation in New Zealand.[15]

The SAFE Tool measures ten domains covering one patient, two staff and seven organisational domains as described in Table 1 – refer to Appendix 1 for further details of the SAFE Tool and its development.

Table 1: SAFE Tool Domains

Domain type	Domain	Definition
PATIENT	1. Identification, first line response, and follow-up	A standard identification and screening protocol and first line response approach to guide appropriate assessment, referral and follow-up when responding to family violence
STAFF	2. Staff education and training	Staff are trained to have a shared understanding of family violence, training is tailored to clinical staff, specialist staff and managers
	3. Staff support	Practical support for all staff to undertake their work to address family violence
ORGANISATIONAL	4. Organisational policies, procedures and guidelines	Up-to-date policies, procedures and guidelines support family violence first-line identification and response for patients and staff using a lifespan approach
	5. Governance and leadership	The health service demonstrates governance, leadership, and investment in family violence program sustainability
	6. Intersectionality and diversity	The program is inclusive and accessible for diverse communities including people with lived experiences of family violence
	7. Collaboration and service integration	Internal and external collaboration throughout family violence program and practice
	8. Infrastructure – physical environment and financial resources	Infrastructure to support the family violence program – physically safe environment in which to seek help for family violence; a fully funded and allocated program supporting dedicated staff and resources
	9. Organisational culture	Organisational culture that demonstrates recognition of family violence and gender equity as an important issue for the health service
	10. Quality improvement and evaluation	Strategic and continuous monitoring with feedback to ensure service effectiveness is achieving its goal of systems change

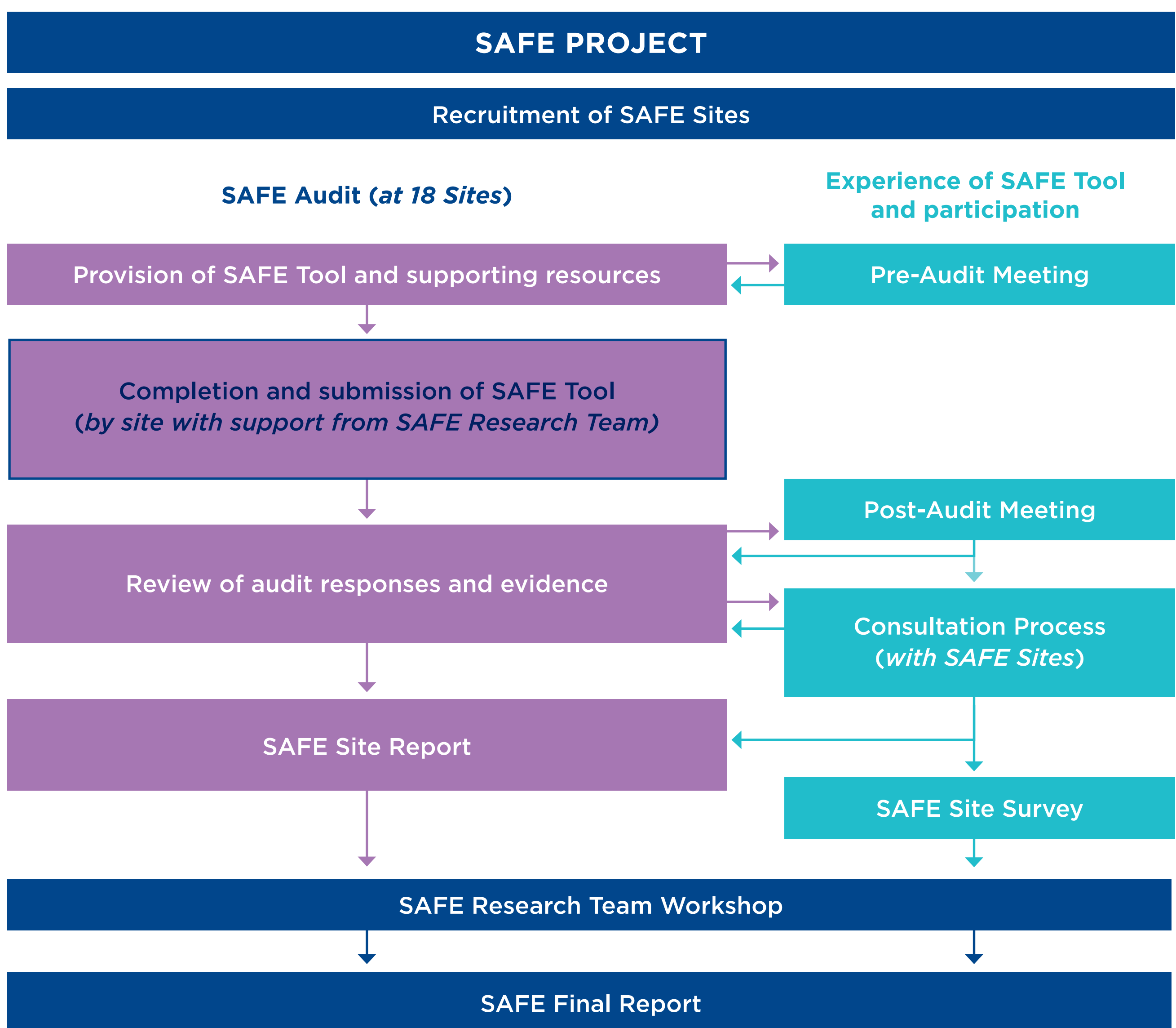
Methods

Methods

Overview

An overview of the methods used in the SAFE Project are outlined in Figure 2. This shows that in addition to conducting the SAFE Audit, a series of meetings and engagement activities with participating SAFE Sites (health services) were undertaken to investigate the experience of administering the SAFE Tool and participating in the SAFE Project.

Figure 2: Overview of the SAFE Project Steps



Details of the SAFE Project Steps

Step 1: Recruitment of SAFE Sites

An expression of interest (EOI) process was distributed to all 88 Victorian health services implementing the SHRFV program. Over half applied so a second EOI process was undertaken, and a shortlist of applicants subsequently interviewed with eighteen selected to participate.

Applicants were assessed on their organisation's:

- readiness and capacity to deliver on the project responsibilities, including implementing the SAFE Tool in their health service
- executive leadership support for the SAFE Project
- willingness to sign a project memorandum of understanding
- internal governance processes to support the SAFE Project's implementation.

Each site/cluster selected was paid $15,000 for the work undertaken in participating in the SAFE Project and administering the SAFE Tool.

SHRFV SITE AND CLUSTER DEFINITIONS

Site – individual health service

Cluster – group of health services (smaller sites plus a larger site providing leadership) that work in partnership to implement the SHRFV program.

Step 2: Provision of SAFE Tool and supporting resources

SAFE Sites were supplied with a copy of the SAFE Tool provided as an Excel Form (interactive excel file) and supporting resources including Clinical Files Audit Tool (excel file) and material to aid their ethics application (as needed).

Step 3: Pre-Audit Meeting

Two members of the SAFE Research Team met with each site/cluster to demonstrate the SAFE Tool and explain the project requirements, including provision of evidence – see Appendix 2 for example Agenda. This prompted the development of *The SAFE Tool Information Pack* to guide and assist in the implementation of the Tool – see Appendix 3.

Step 4: Completion and submission of the SAFE Tool

A representative(s) from each participating SAFE Site administered the SAFE Tool. Data collection included:

- audits of medical records
- audit of policies, procedures and resources for patients and staff
- review of documentation
- scrutiny of family violence training programs
- consultation with staff
- consideration of the physical and cultural environments
- review of collaborative arrangements (internal and external)
- checking of material on the organisation's intranet and website
- review of responses.

The SAFE Research Team was available to answer questions and provide support throughout. Sites submitted the completed (self-audit) SAFE Tool to the SAFE Project Manager.

Step 5: Post-Audit Meeting

After each SAFE Tool was submitted, two members of the SAFE Research Team met with relevant people from the SAFE Site (e.g., SHRFV Team, appropriate Managers and/or Directors) to:

- discuss the organisations SHRFV program and resourcing at the time of audit
- seek feedback on participation in the SAFE Project and administering the SAFE Tool
- consider the preliminary SAFE audit results for the site – highlights and opportunities
- mention any issues with responses and/or evidence provided that required follow up
- identify the priorities for improvement at the site, informed by the SAFE Audit.

(See Appendix 4 for example of Post-Audit Meeting details: Agenda and Discussion Guide.)

Step 6: Review of SAFE Tool responses in consultation with site

The SAFE Research Team reviewed and analysed the responses and evidence submitted. They conducted a 'Consultation Process' with sites, again meeting with each separately to discuss any issues with the submitted responses, evidence and/or interpretation of the indicators and measurement notes – additional ongoing communication was frequently required. Sites were then provided with the opportunity to revise their responses and/or evidence and submit a (amended) *final* SAFE Tool. This process was undertaken to check for obvious mistakes and provide some uniformity in interpretation of the SAFE Tool *Items* and *Measurement* notes.

Step 7: Writing of individual confidential SAFE Site Report

Based on the final SAFE Tool results, and information provided at the Post-Audit Meeting and Consultation Process, the SAFE Research Team prepared a confidential SAFE Site Report for each of the eighteen participating health services. Appropriate people from each site (e.g., SHRFV Team, SHRFV Executive Director) were invited to review the SAFE Site Report prior to it being provided to the organisations Chief Executive Officer.

Step 8: Feedback via the 'SAFE Site Survey'

A 'SAFE Site Survey' was conducted to give participating organisations the opportunity to provide feedback on the SAFE Audit Tool and administration of it at their health service. Some context questions were also included (see Appendix 5 for survey questions). This short online survey, taking 5-10 minutes to complete, was voluntary and responses anonymous. Invitees were advised that answers to fixed choice questions would be presented as aggregate results, while responses to open ended questions would be reviewed and unidentified quotes potentially used in reports, publications, and presentations. Invitations for one person from each health service to participate in the survey were emailed to all eighteen SAFE Sites between 25 to 28 June 2021. A reminder/notice of extension to closing date was emailed on 6 July and the survey closed on 1 August 2021.

Step 9: SAFE Research Team Workshop

The SAFE Research Team held a half day synthesis workshop on 8 July 2021 where findings were brought together and discussed.

Development of the SAFE Project Final Report

The Final SAFE Report (informed by the confidential SAFE Site Reports) brings together:

- SAFE Tool results
- information gathered through the SAFE Site meetings and consultation/engagement
- SAFE Site Survey results
- SAFE Research Team Workshop synthesis.

Data analysis

SAFE Tool results from participating sites were entered into a excel spreadsheet and exported to IBM SPSS (Version 26) statistical software package for descriptive analysis. Results are presented in this report as frequencies, median (or middle) scores and spread using boxplots (see Appendix 6 for interpretation of boxplots).

Information gathered from meetings and engagement with SAFE Sites, and the SAFE Site Survey, was synthesised at the SAFE Research Team Workshop and used to expand and develop the findings, with anonymous quotes used to provide illustration. Throughout this report care has been taken to ensure anonymity of participating sites.

Timeline

The SAFE Project was officially launched at the Women's International Women's Day Breakfast on 8 March 2019. The eighteen participating SAFE Sites were announced on 1 July 2019 and SAFE Sites participation was administered in three stages as outlined in Table 2. Work culminated in this final SAFE Report dated November 2021.

Table 2: SAFE Project timeline

Stage	No of Sites	Pre-Audit Meetings	Audit Tools Submitted	Post-Audit Meeting	SAFE Site Reports (n = 18)
Stage 1	9	November 2019	30 March 2020 – 22 April 2020*	16 June – 21 September 2020	March 2020 – August 2021
Stage 2	3	May 2020	23 November 2020 – 14 December 2020	7 – 17 December 2020	
Stage 3	6	July/August 2020	16 December 2020 – 1 April 2021	9 March – 18 May 2021	

*One Stage 1 site was granted an extension until 6th August 2020 to capture the operationalisation of their SHRFV work

Ethics

The SAFE Research Team supported all participating SAFE sites gain quality *assurance/quality improvement and innovation/audit/evaluation activity* approval through their organisation's ethics approval process with cluster sites covered under their Lead site's approval.

Findings in context

Findings in context: The SAFE Audit

Impact of COVID-19

The SAFE Project was conducted in the context of the COVID-19 pandemic which has had a significant impact on all health services. SAFE Sites have been required to directly respond to the public health crisis. COVID-19 restrictions also forced the design and implementation of new models of service delivery for patients (telehealth) and online education and training strategies for staff.

Furthermore, a significant number of SHRFV staff, and the SAFE Research Team, worked from home during the SAFE Project to comply with COVID lockdowns.

The key implications for the SAFE Project have been:

- reduced access to health service records and colleagues while working off site
- interruptions to the audit process due to SHRFV staff redeployments
- replacement of planned visits to participating sites by the SAFE Research Team to video conferencing, telephone, and email communications
- SAFE Research Team meetings largely online.

EFFECT OF COVID-19 PANDEMIC ON FAMILY VIOLENCE PRACTICE

Staff responded to situations including:

- use of telehealth for risk assessment and management for patients
- process for responding to staff at risk and working from home
- system of support for frontline practitioners delivering services from hospital or their own homes
- restricted staff education and training opportunities.

Context of SAFE Sites

The eighteen SAFE Sites selected were diverse and their history of involvement in the SHRFV program varied. They comprised six metropolitan and twelve regional and rural health services. 'Lead', 'Standalone' and 'Supported' health services were all included (with whole-of-cluster representation). Sites ranged in size from around 150 to over 7,000 staff. Sites also differed in the range and extent of clinical services provided, and the demographics of sites service populations varied according to location and speciality services offered.

Commencement of the SHRFV program at the sites was from 2014 to 2018. Sites reported that staff resourcing of the SHRFV work varied over time being impacted by budgets and COVID-19 disruptions. Peak staffing levels differed appreciably between sites, however, when the SAFE Audit was conducted sites' staff allocation to the program of work ranged from no dedicated SHRFV staff (with work being absorbed into other roles) to around 2.3 EFT (exclusive of in-kind support).

LEAD, STANDALONE AND SUPPORTED SERVICES

SHRFV deliverables are based on health services being one of the following:

Lead – perform a leadership role in SHRFV implementation, including leading a cluster of smaller health services

Standalone – have no responsibilities to lead, support or mentor other sites

Supported – a small health service that is part of a cluster of sites mentored and supported by a cluster Lead.

SAFE Tool Results

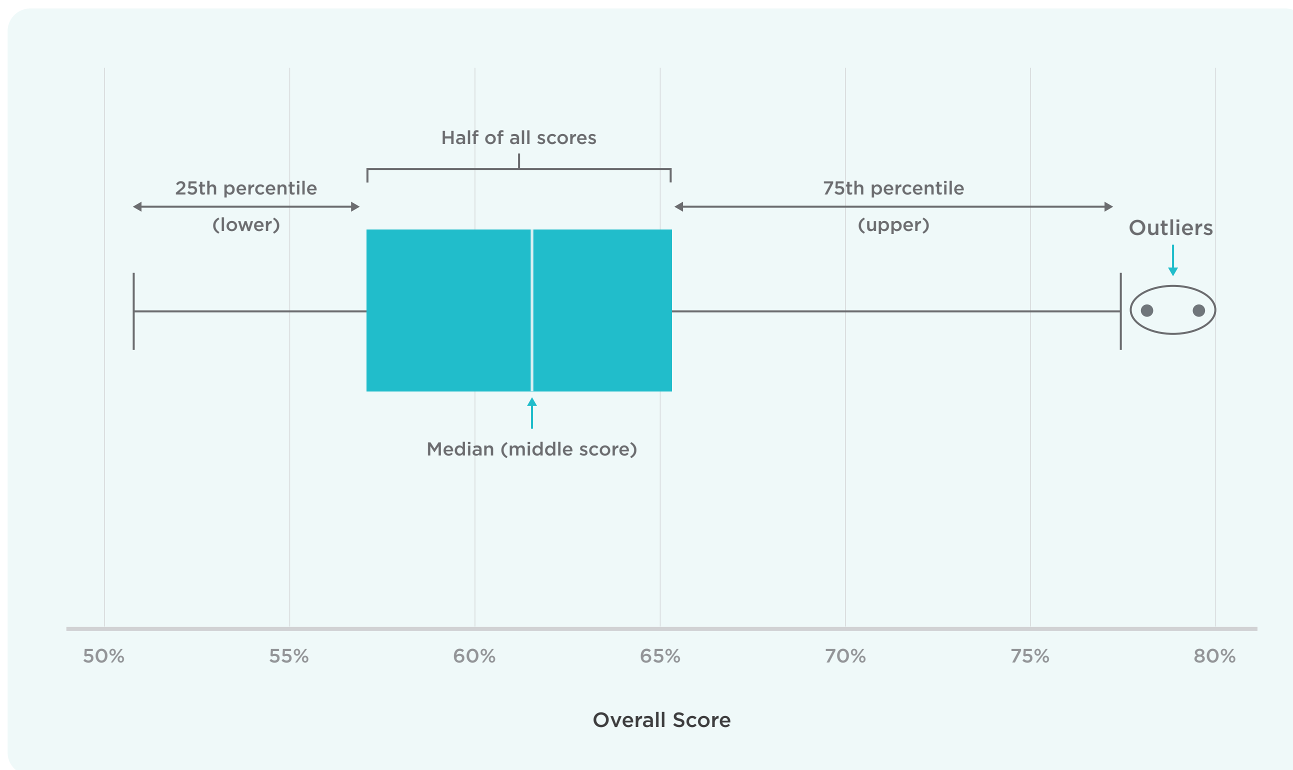
The SAFE Tool provides ten Domain Scores presented as a percentage where 0% signifies no indicators achieved and 100% signifies all indicators achieved. An Overall Score is also generated, derived using a weighting scheme applied to the Domain Scores as outlined in Appendix 1 and Table 3 on p.25 (weightings reflect the importance and contribution of the domains in the Overall Score). A higher score indicates a higher level of family violence program development.

Overall Score

The Overall Scores for sites ranged from 50.8% to 79.6%, three scoring 77.4% and above, and half scoring between 59.8% and 65.3% (see Figure 3 (below) and Table 3 (on p.25)). The mean (average) was 62.5% and the median (middle value) was 61.6% – also see Figure 4 (Appendix 6 provides further details of Boxplot interpretation).

Figure 3: Overall Scores: All SAFE Sites

Figure 4: Overall Scores: Summary from SAFE Sites

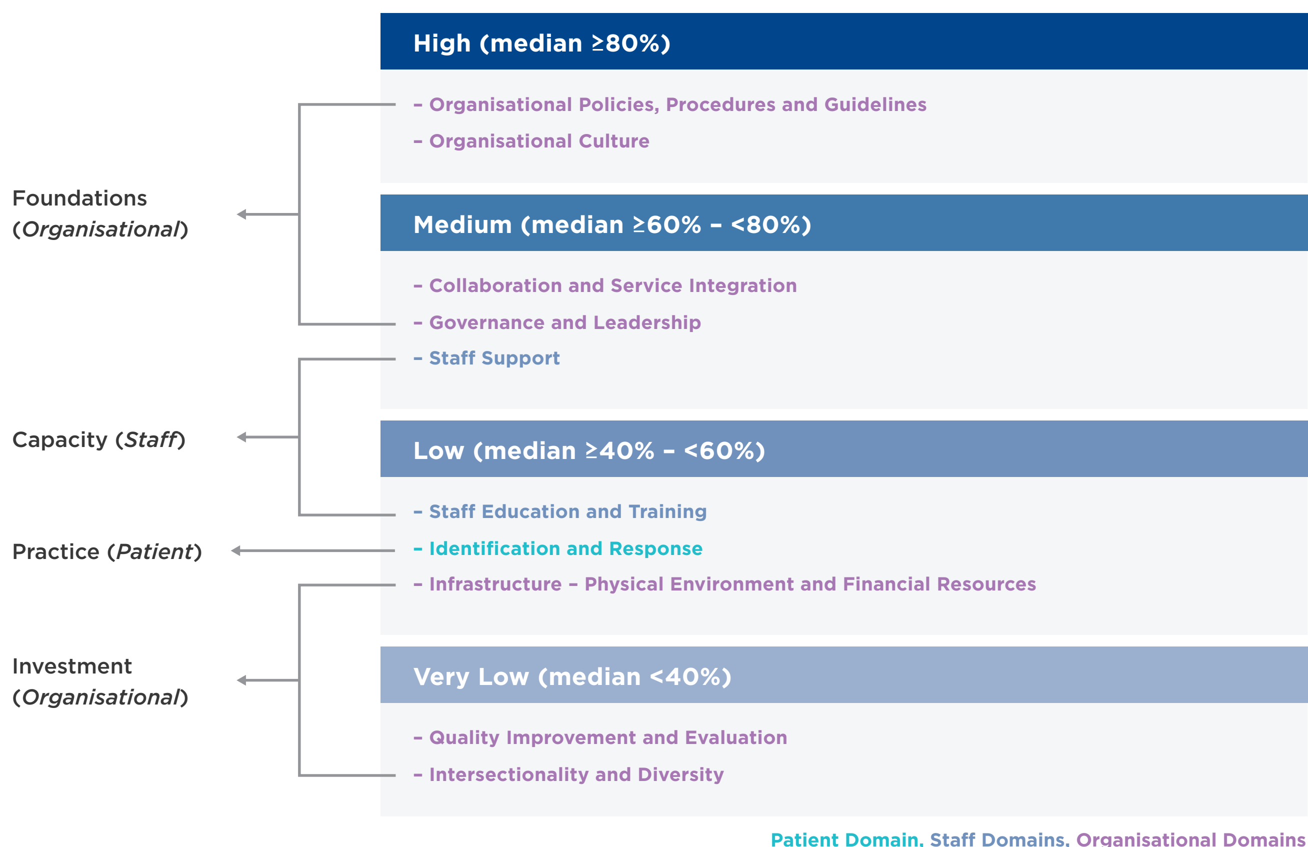


These Overall Scores suggest that while the health services have systems in place to respond to family violence, there continues to be a need for further resourcing and improvement in a range of domains at all participating sites. There was general consistency across the SAFE Sites - three sites scored very well (including the two outliers as per Figure 4) and although none were outstanding, neither was any site significantly lower than the rest.

Domain Scores

SAFE Site results for each of the ten domains outlined in the SAFE Tool (one Patient Domain, two Staff Domains and seven Organisational Domains) were ordered from highest to lowest, based on median (or middle) scores, with domains then grouped as *high, medium, low,* and *very low* areas of practice as described in Figure 5.

Figure 5: Domain Score performance (based on Domain medians)



Not surprisingly the pattern formed by this ranking of domain performance largely aligned with SHRFV implementation strategies at health services.

The four highest performing Domains were those that covered the organisational foundations crucial in realising a whole-of-organisation response to family violence – *Policies, Procedures and Guidelines, Culture, Collaboration and Service Integration and Governance and Leadership.*

Next were the two Staff Domains, *Staff Support and Staff Education and Training*, important in building internal capacity and capability, a necessary step before the practice of patient-centred care could be appropriately undertaken by staff who are supported both professionally and personally in this endeavour.

Identification and Response, the only Patient Domain, ranked next. The position of this domain (placing it near the lower third of the median domain scores) indicated sites had focused on the groundwork of the health services family violence response but the important patient facing work remains an area for development and improvement.

The three lowest scoring domains covered organisational investment which would help embed the family violence work within the health service and facilitate a sustainable and effective family violence program with expanded reach and access: *Infrastructure – Physical Environment and Financial Resources, Quality Improvement and Evaluation, Intersectionality and Diversity.*

A summary of the results for the ten Domain Scores are outlined in Table 3 (on p.25) with visual representation via Boxplots found at Figure 6 (on p.26). SAFE Site scores are then presented (anonymously and ordered from highest to lowest) for each domain and discussed.

Table 3: Domain Scores: Analysis

	Domain	Weight+	No. of items++	Min	Max	Range	Mean	Median
1^	Identification and Response	19	13	35	87	52	54	53
2#	Staff Education and Training	10	7	39	97	58	57	55
3#	Staff Support	9	6	54	88	34	73	71
4*	Organisational Policies, Procedures and Guidelines	9	6	78	100	22	92	94
5*	Governance and Leadership	11	7	34	100	66	73	73
6*	Intersectionality and Diversity	8	7	15	72	57	39	35
7*	Collaboration and Service Integration	8	3	57	100	43	75	74
8*	Infrastructure – Physical Environment and Financial Resources	8	7	6	63	57	41	44
9*	Organisational Culture	10	7	56	100	44	83	88
10*	Quality Improvement and Evaluation	8	8	11	75	64	36	36
Overall Score		**–**	**71**	**50.8**	**79.6**	**28.8**	**62.5**	**61.6**

Note: ^ Patient Domain; | # Staff Domain; | * Organisational Domain.
+ Weightings have been applied to reflect the importance and contribution of these elements within the SAFE Tool. Weighted Domain Scores are summed to give an 'Overall Score'.
++ Items (indicators) were weighted to reflect the importance and contribution of these elements to the Domain Score.

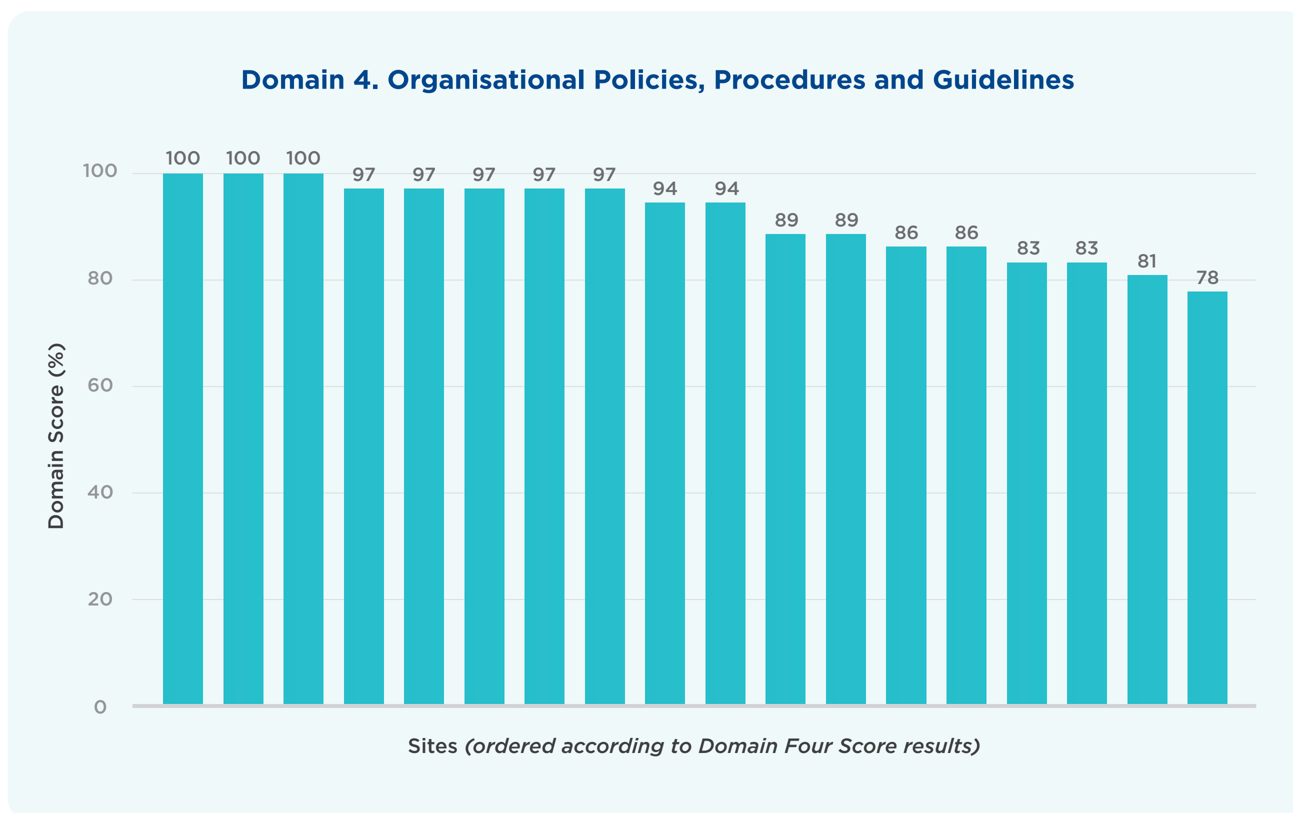
Figure 6: Domain Scores: Boxplot

High performing domains (median ≥80%)

Organisational Policies, Procedures and Guidelines (median = 94%)

This domain was the strongest area indicating there are up-to-date documentation of policies, procedures, and guidelines to support the identification of and response to family violence for both patients and staff. Further, this domain had the smallest variability in scores, all being above 77%, and ten sites scoring above 93% – see Figure 6 p.26 and Figure 7 below.

Figure 7: SAFE Site scores for 'Domain 4. Organisational Policies, Procedures and Guidelines'



The high performance in this domain may in part be attributable to relevant template documents being available in the SHRFV Toolkit which all health services can access.[16] To illustrate, when asked what has worked well in relation to SHRFV implementation, one SAFE Site Survey participant said:

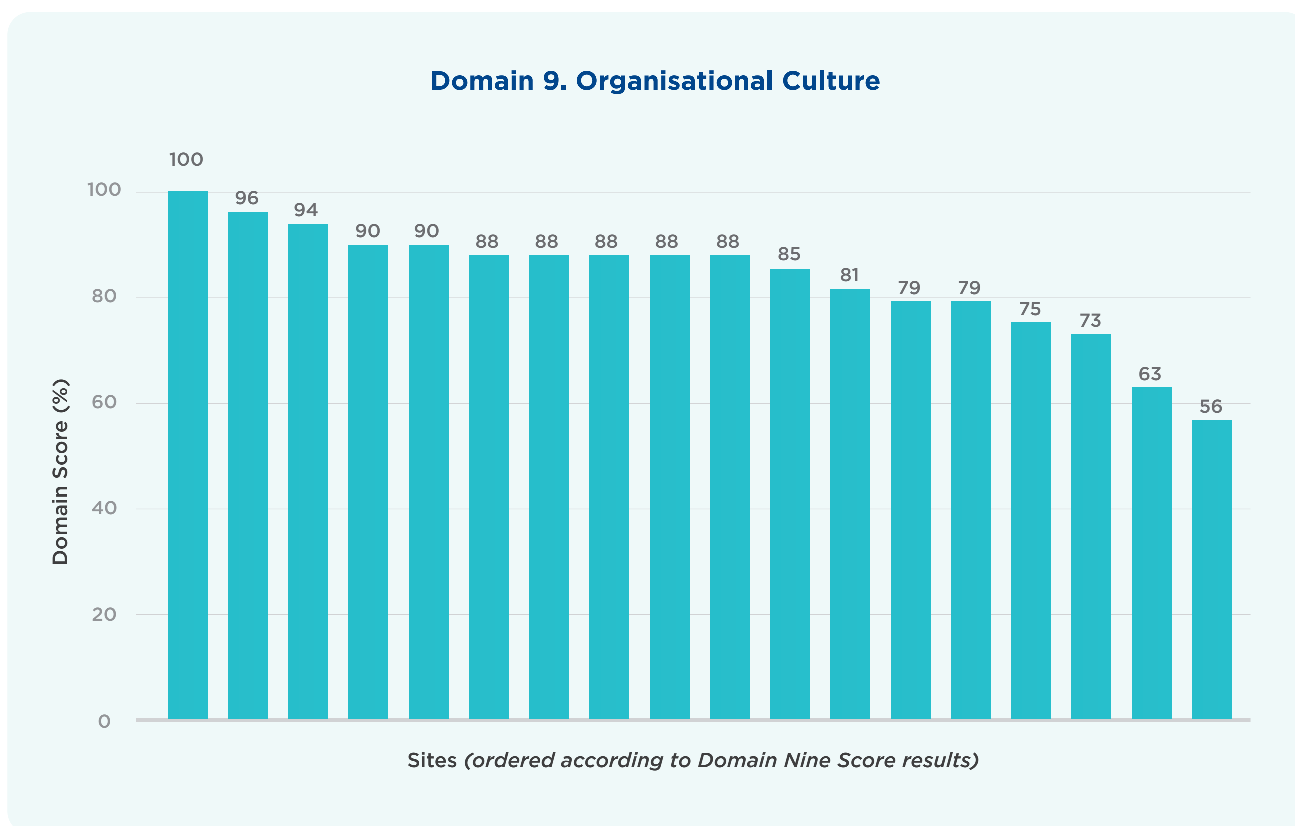
> *[Things that have worked well in relation to implementation of SHRFV at our site include] … shared policies and procedures and regular updates with regards to any changes to regulations.'*
>
> (SAFE Site Survey participant)

Organisational culture (median = 88%)

This domain also scored highly with nearly all sites (16/18) scoring over 72%, while the remaining two scored significantly lower (outliers) – see Figure 6 p.26 and Figure 8 below. This result reflects the sites' general recognition of family violence as a women's health issue and commitment to gender equity. In promoting a culture of gender equity, health services promoted actions to help prevent violence against women and created a supportive environment for responding to family violence.

All except one site indicated they had communication and messaging, including on the organisation's website, providing information about family violence as a health issue. All had a policy that responds to staff bullying and sexual harassment, and almost all (16/18) indicated there were initiatives or strategies from their health service that promote gender equitable, respectful behaviour and attitudes in the workplace. Furthermore, at the time of the audit sixteen sites were organisations where fifty percent or more of the health service's executive were women, for over half the Chief Executive Officer was a woman.

Figure 8: SAFE Site scores for 'Domain 9. Organisational Culture'



In this domain staff views concerning workplace gender equality indicators were evaluated by including items that drew on the latest People Matter Survey results (Victorian public sector's annual employee opinion survey).[17] However, a small number of SAFE Sites did not participate in this Survey and their submitted responses, with supporting evidence to match the intent of the indicator if applicable, were accepted. Therefore, it is recognised that there were some issues and inconsistencies with these Domain Scores.

The *Gender Equality Act 2020*, which recognises that "gender equality is a precondition for the prevention of family violence and other forms of violence against women and girls"[18 p7], commenced on 31 March 2021 meaning the SAFE audit timeframe was prior to its introduction. Given this, and the high performance in this domain, there is the potential to consider more aspirational measures which will align with the work being conducted in response to obligations under this Act.

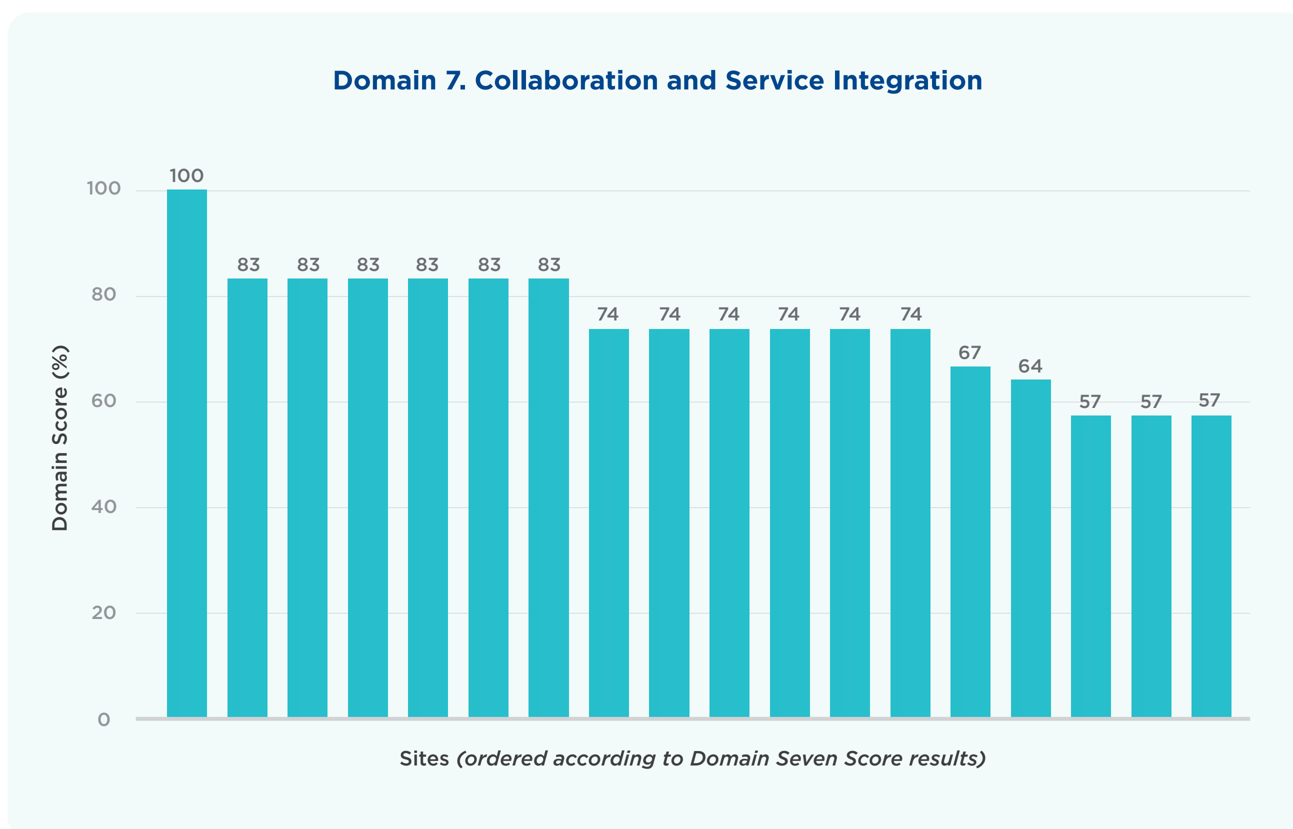
Medium performing domains (median ≥60% to <80%)

Collaboration and Service Integration (median = 74%)

Results for this domain indicate that sites have been working through the family violence program work on both internal and external collaboration. However, SAFE Site scores varied with one site achieving 100%, and three sites scoring 57% (see Figure 9).

A number of SAFE Sites pointed out that their SHRFV programs featured collaborative interdisciplinary work and/or service integration with relevant specialist departments/areas. Further, responses indicated that positive working relationships have been developed with relevant services both within and beyond the participating site, an achievement highly valued by some of the health services.

Figure 9: SAFE Site scores for 'Domain 7. Collaboration and Service Integration'



> ***Meaningful collaborations across program areas and with external agencies [has worked well in relation to implementation of the SHRFV at our site].***
> **(SAFE Site Survey participant)**

In some cases, these relationships have been enhanced by the co-location/positioning of family violence services (e.g., The Orange Door) or CASA's (Centre Against Sexual Assault) within the health service. Collaboration, referral pathways and/or service integration with perpetrator services was not established at four sites, suggesting some work needs to be done this area.

Fourteen sites have health service representatives attend local interagency meetings such as The Orange Door,[19] No To Violence,[20] or RAMP (Risk Assessment and Management Panel) meetings.[21] It is acknowledged that smaller rural sites may have less opportunity to engage in these activities. In general, formalising arrangements or partnerships (for example through memorandums of understanding or service agreements (MOU)) have not been addressed at sites, however, in the future a MOU with The Orange Door could be considered.

SERVICES AND ORGANISATIONS

The Orange Door: entry point for Victorians to access family violence and child and family services.[19]

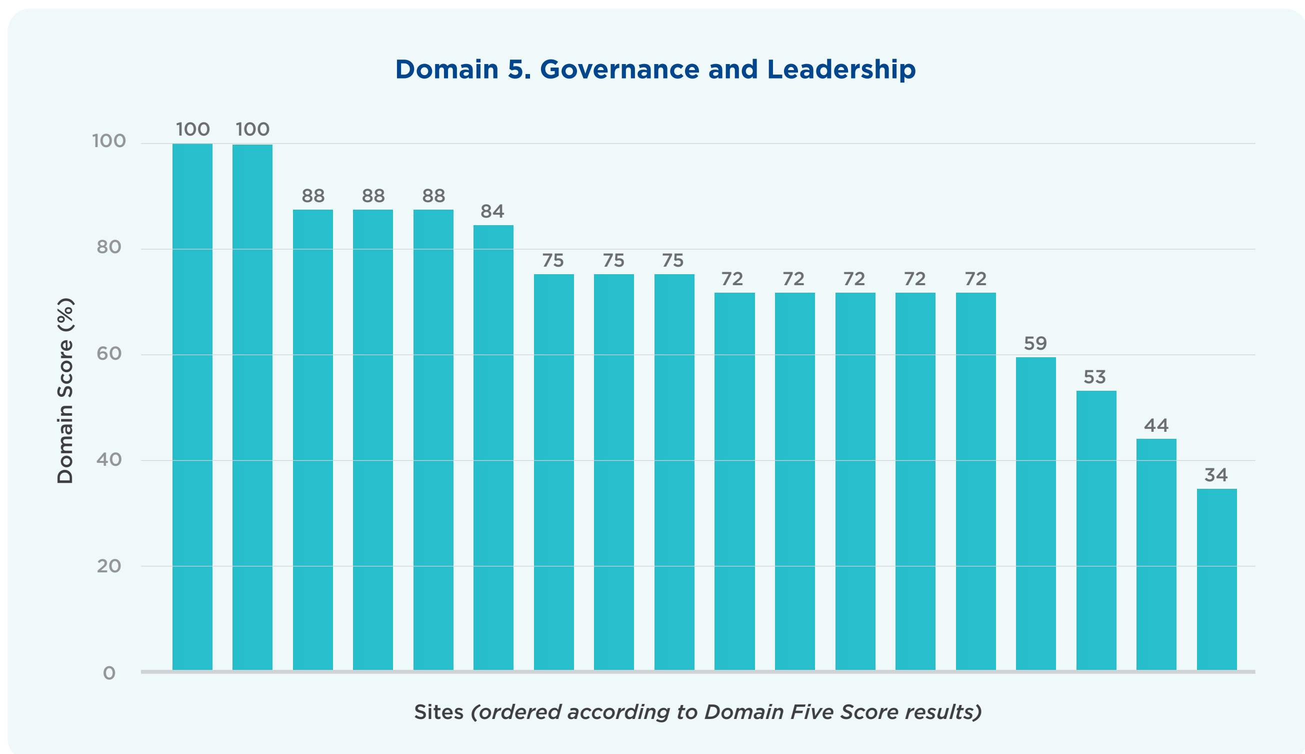
No To Violence: peak men's services organisation.[20]

RAMP (Risk Assessment and Management Panel) meetings: representatives from relevant local agencies convene for the purpose of contributing to the safety of women and children who are experiencing serious and imminent threat from family violence.[21]

Governance and Leadership (median = 73%)

While a medium area of practice, the range of scores for this domain varied more than any other domain – two sites scored 100% which contrasted with two (outliers) scoring below 45% (see Figure 6 p.26 and Figure 10 below). That said, the results indicate that in general sites' boards, executive, and senior staff have demonstrated some commitment to strengthening the health service's response to family violence and sustainability of the work. All eighteen SAFE Sites had an executive lead for family violence. Seventeen had a governance group or steering committee/group with clearly defined roles and responsibilities for strategic leadership of the family violence program (the remaining site was without such a group as the previous one was interrupted by COVID-19). However, many sites could strengthen this domain if they had a standalone strategy and/or operational plan (six sites had family violence included in their Strategic Plan) with key performance indicators and an evaluation framework for their family violence program (eight had this in existence).

Figure 10: SAFE Site scores for 'Domain 5. Governance and Leadership'



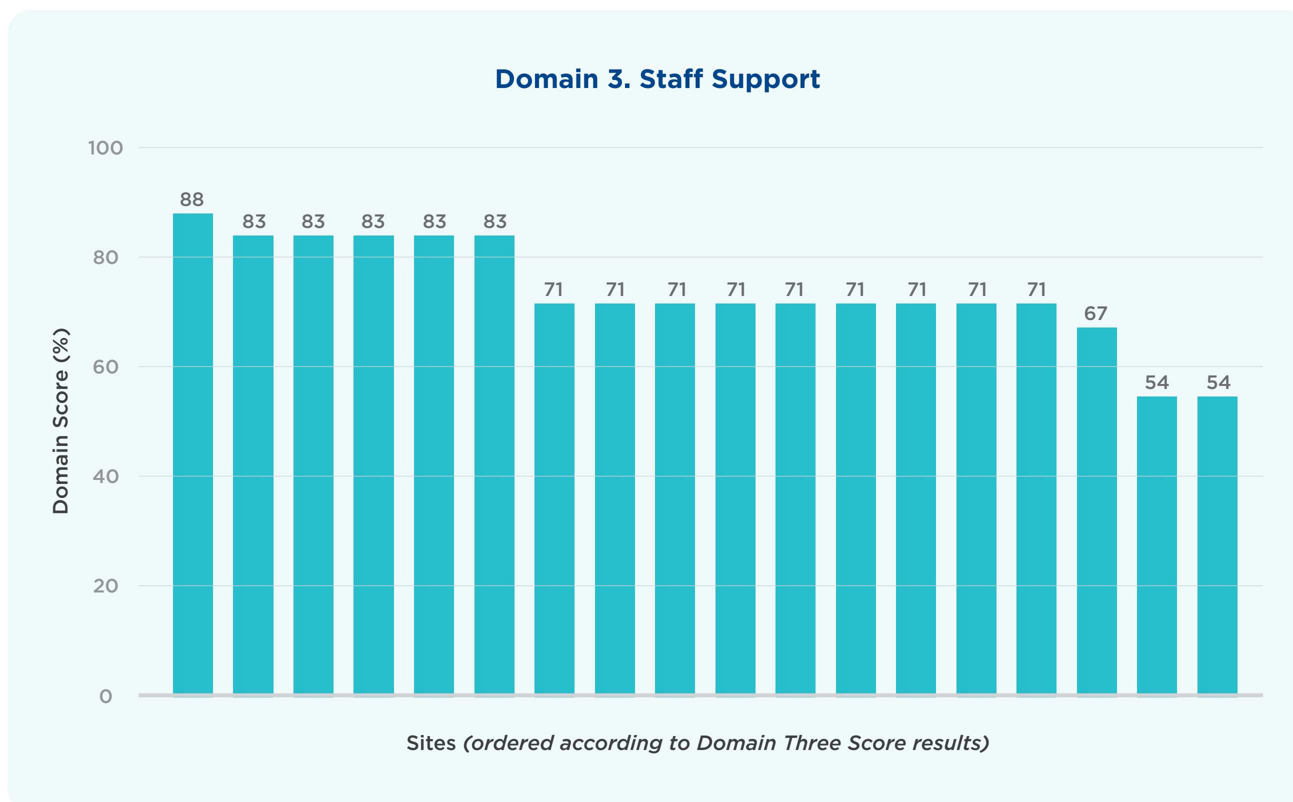
The SHRFV Toolkit[16] provides guidance around governance, leadership and executive sponsorship which may also have supported achievements in this domain. Further, the presence of family violence in the Statement of Priorities (agreement between the Victorian Government Minister for Health and health services) may be a contributory factor to the inclusion in strategic planning at many sites. However, this stimulus will not be ongoing unless family violence continues to be included in this agreement, and/or it is included in the National Safety and Quality Health Service (NSQHS) Standards.[22] This would provide a nationally consistent statement around care patients/clients can expect from health services regarding family violence.

Staff Support (median = 71%)

Another medium performing domain signifying sites are working at creating an environment where there is good practical support for all staff to undertake their work to address family violence – sixteen sites scored over 60%, fifteen over 70% (see Figure 11).

The inclusion of the Family Violence Leave Clause in Enterprise Agreements has driven health services to establish human resource systems that offer this leave and support victim survivors in the workplace. All sites indicated staff use of family violence leave is monitored, however only one evaluated staff experiences of family violence workplace support.

Figure 11: SAFE Site scores for 'Domain 3. Staff Support'



Nearly all (17/18) had specifically trained Family Violence Clinical Champion(s) to support staff responding to family violence, and/or Family Violence Contact Officers, trained to assist staff who have experienced family violence with workplace supports such as family violence leave, safety planning and referral. However, the domain would be strengthened if sites routinely conducted an evaluation of the Clinical Champion and/or Contact Officers program – currently 6/18 undertook this.

Results in this domain reflect the fact that Workplace Support has been an important focus of the SHRFV program – partly in response to Australian research which found the prevalence of family violence against health workers was significantly higher than in the general community.[23] Appropriate resources are available for sites on the SHRFV website.[4]

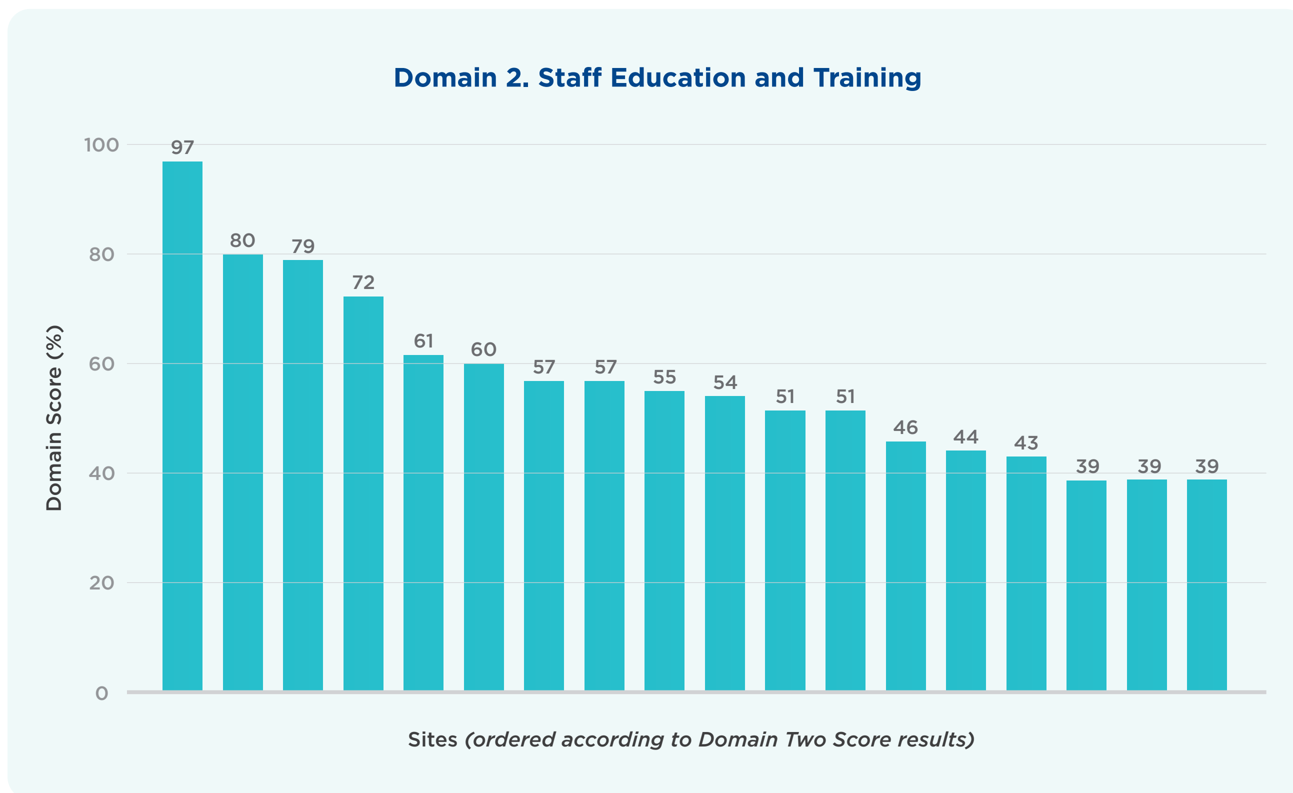
> ***'Our staff are part of our community. Supporting and educating our staff not only builds capacity internally but enable us to engage with our community and raise the profile of family violence and family violence support services.'***
>
> **(Comment via engagement with site)**

Low performing domains (median ≥40% to <60%)

Staff education and training (median = 55%)

This domain was an area with considerable variation in individual site scores. Most were between 39% and 80%, however, there was one standout site (outlier) with a Domain Score of 97% (see Figure 6 p.26 and Figure 12 below).

Figure 12: SAFE Site scores for 'Domain 2. Staff Education and Training'



Scores for this domain reflect the fact that the SAFE Tool asked about *mandated* training for all clinical staff (re inquiry, risk assessment, referral, and follow-up), specialist staff (re risk assessment, safety planning, and case management), and managers (re responding to family violence disclosures by staff and workplace support). Mandatory training was not the case for most sites as shown in Table 4 which details responses to staff training indicators.

Table 4: SAFE Tool Results for designated family violence training indicators

Designated family violence training indicator	Yes	No
Part of orientation and ≥80% of new staff complete this training	7	11
All clinical staff are mandated to attend best practice family violence training on inquiry, risk assessment, referral, and follow-up?	2	16
All specialist staff are mandated to attend family violence training on comprehensive risk assessment, safety planning and case management?	7	11
Manager training about responding to family violence disclosures by staff, and the family violence workplace support provisions available, is mandated and all managers attend?	9	9

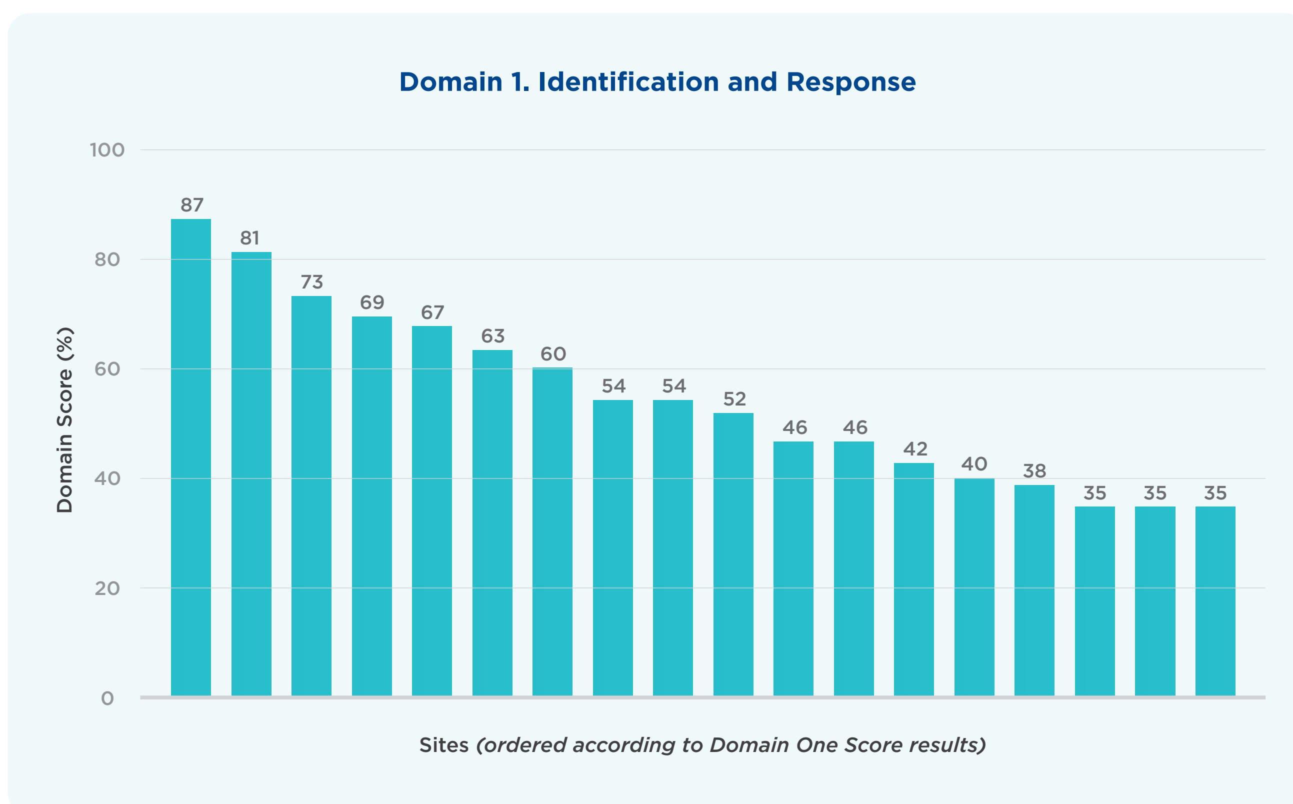
It is acknowledged that considerable work has been undertaken in this area and it has been an important focus of the SHRFV programs. The online SHRFV Resources Centre provides SHRFV training material to cover all staff employed at health services and is available for use as is, or can be adapted to individual health service settings and clusters.[4] Importantly, staff education and training was disrupted during 2020 due to COVID-19 – this included such things as a freeze on training, cessation of face-to-face training and a move towards other delivery modes.

The majority of sites had mechanisms for regular case discussions and case reviews about patients/clients who are experiencing family violence within the health service (14/18) and at an interagency level (12/18).

Identification and Response (median = 53%)

Scores for the single patient domain, *Identification and Response*, also varied considerably ranging from 35% (three sites) to 87% – see Figure 13.

Figure 13: SAFE Site scores for 'Domain 1. Identification and Response'



Note that in addition to covering health services preparedness to operationalise patient intervention, five items in this domain required undertaking clinical file audits to consider clinical practice; thirteen SAFE Sites performed this substantial work which is detailed below (see Clinical Files Audit). Where sites did not conduct the specified/relevant clinical files audit, no points were allocated to the corresponding indicators.

Overall, findings from this domain show that there is still considerable work to be done to enhance family violence identification and response. Clinical guidelines, and standardised tools (along with delivery of training and support for staff) as recommended by the SHRFV Toolkit[16] require additional resourcing for implementation at the practice level.

The MARAM framework[9] provides guidance and new impetus in this area. It is acknowledged that the SAFE Audit was conducted prior to MARAM prescription for health services (19 April 2021),[24] and given the phased rollout of the SAFE Audit sites were at vary levels of preparedness for the introduction of MARAM when the SAFE Tool was administered.

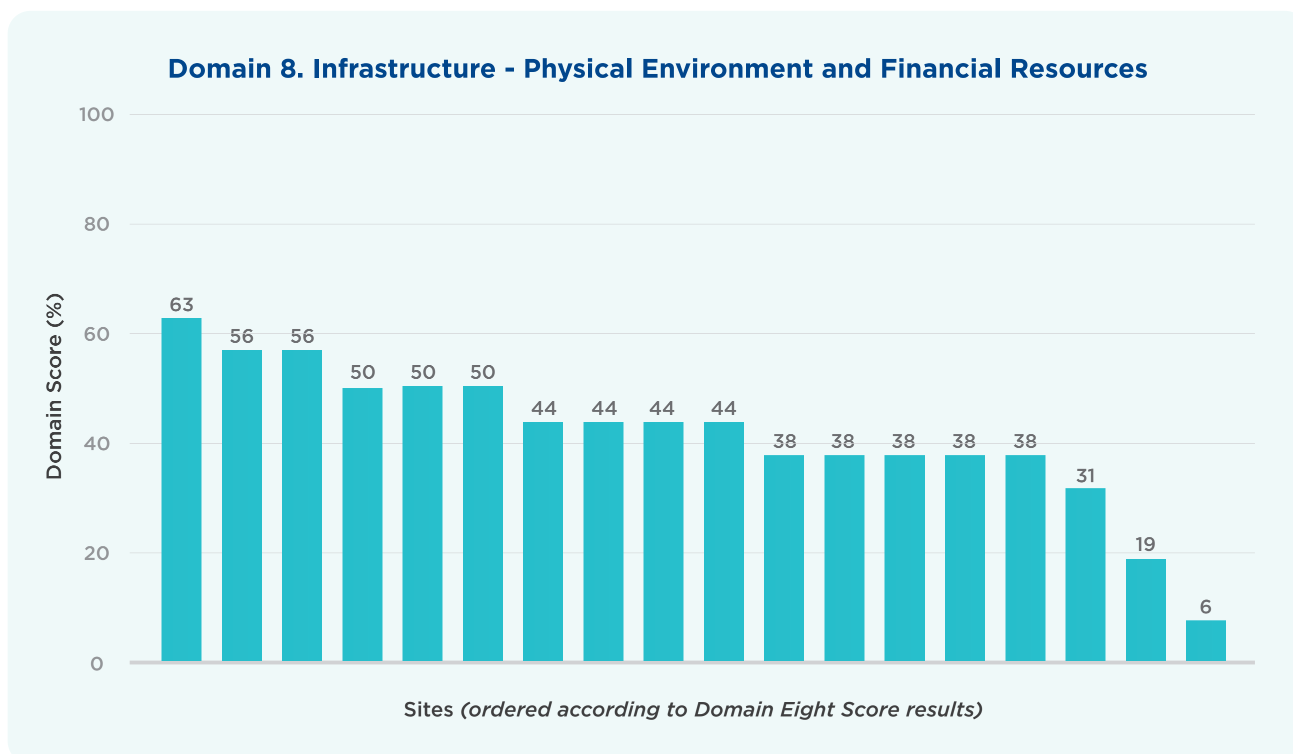
> ***The SAFE project and patient audit request revealed gaps in our auditing and reporting systems.***
>
> **(SAFE Site Survey participant)**

Infrastructure – Physical Environment and Financial Resources (median = 44%)

Infrastructure – Physical Environment and Financial Resources was another domain where sites' scores were generally low – all except one site scored below 60% and eight scored below 40% including one outlier scoring 6% (see Figure 6 p.26 and Figure 14 below).

There was a clear demarcation between the two aspects of this domain. In general sites considered themselves to be performing well in creating a physical environment that is safe to seek help for family violence and promotes staff and patient safety. A component of the audit area concerned the display of family violence posters and brochures thus sites were disadvantaged if they were not permitted to exhibit material in this way (i.e., posters not permitted in new buildings, brochures not allowed due to COVID-19 restrictions) or had specifically decided against these activities (instead providing material when safe to do so and when requested).

Figure 14: SAFE Site scores for 'Domain 8. Infrastructure – Physical Environment and Financial Resources'



In contrast, the absence of dedicated ongoing funding to sustain, improve and extend sites family violence work impacted *all* scores in this domain. More broadly a lack of funding certainty and hence resource allocation was a significant issue which negatively impacted family violence work in the health services. Sites spoke of how addressing this was important in order to create certainty and confidence (at both a program and individual/staff level) and retain dedicated staff who have built expertise in the area. This is necessary for planning and developing a mature family violence program of work from which to build health service proficiency across patient, staff, and organisational domains. As one SAFE Site Survey participant said:

> ***Annual funding has not been overly helpful, especially when confirmation doesn't come until after the end of people's contracts. I am aware many SHRFVs have struggled to keep staff due to this. The lack of certainty and clarity has been a challenge and has caused a lot of stress to staff already working under very difficult circumstances. Clear funding into the future enabling dedicated resourcing is desperately needed in this important health space.***
>
> **(SAFE Site Survey participant)**

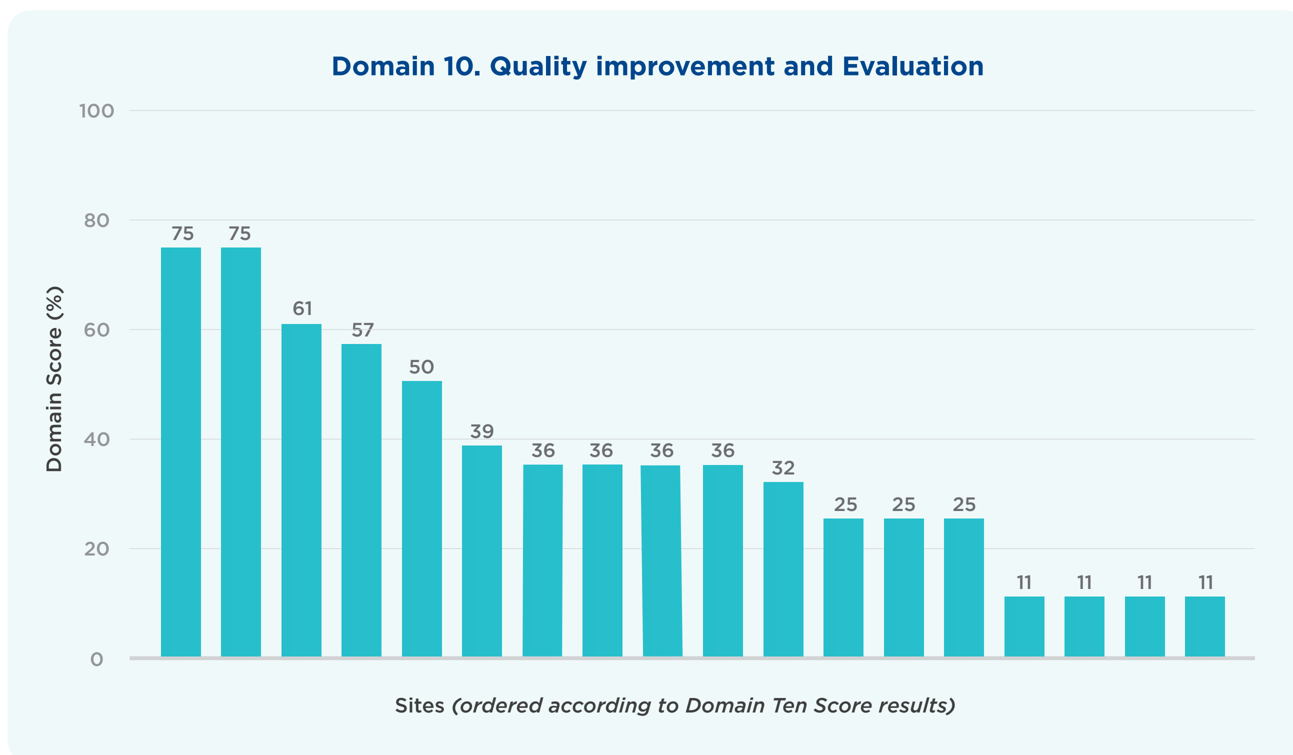
Further, having a dedicated project role and stable SHRFV teams were seen as important factors in the ongoing success of SHRFV implementation.

Very low performing domains (<40%)

Quality Improvement and Evaluation (median = 36%).

Although most sites struggled in this domain (13/18 scored less than 40%), there was a wide range of scores evenly spread between 75%, and 11% (see Figure 15).

Figure 15: SAFE Site scores for 'Domain 10. Quality Improvement and Evaluation'



Details of some activities that *strengthened* SAFE Sites scores in this domain included:

- three sites reported that patients/clients who experience family violence provide feedback on the family violence program
- three sites indicated that health service demand associated with family violence is regularly reviewed and increased demand resourced
- five sites had databases and/or routine systems that collect family violence program information including periodic case file audits of family violence identification, screening, and response.

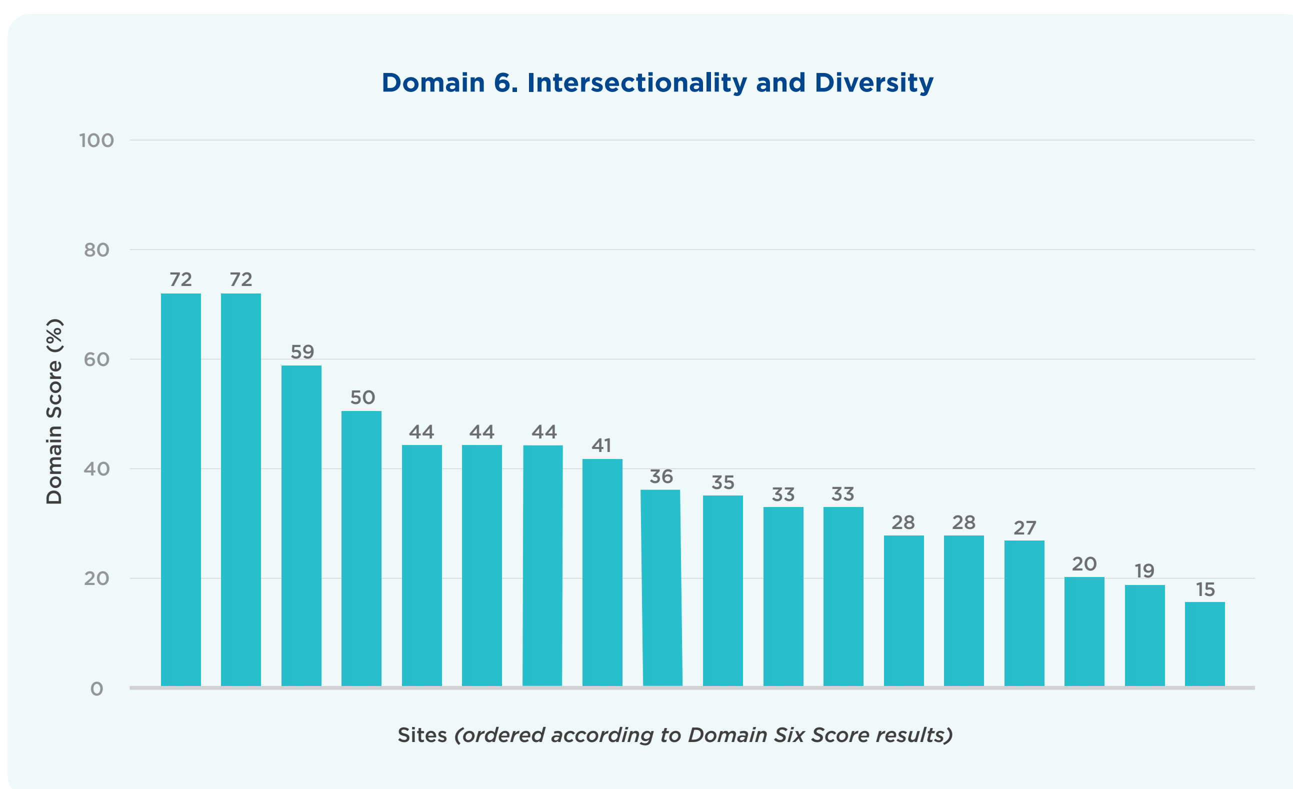
Overall, however, the results here indicate that there is work to be done in integrating the family violence program into patient feedback, data collection and quality improvement systems. The SAFE Audit could be one mechanism to improve scores on this domain thereby achieving family violence systems change and contributing to the sustainability of the family violence work.

Intersectionality and Diversity (median = 35%)

This domain had the lowest median score showing that the majority of health services are challenged by addressing inclusivity and accessibility. Whilst two outliers scored 72%, all other sites scored below 60% with fourteen below 45% – see Figure 6 p.26 and Figure 16 below.

For a range of groups in society, family violence may be less well understood by the community and service providers. This includes Aboriginal and Torres Strait Islander people; culturally and linguistically diverse communities; older people; people with disabilities; people in rural, regional and remote communities; lesbian, gay, bisexual, trans and gender diverse and intersex communities; and male victims.[25] Where work was being done in health services, it was predominantly around strategies in regard to Aboriginal and Torres Strait Islander peoples. Four sites indicated they sought feedback from Aboriginal victim survivors who come to the service, and five sites indicated staff receive Aboriginal and Torres Strait Islander cultural competency training. However, the SAFE Audit showed actions to address equitable access for all communities needs further attention (e.g., inclusion of family violence in health services diversity plans) and that this may be shaped by the intersectional analysis in the MARAM Framework.[9]

Figure 16: SAFE Site scores for 'Domain 6. Intersectionality and Diversity'



Clinical Files Audit

The SAFE Tool comprises six items (five in *Identification and Response, one in Intersectionality and Diversity*) requiring responses based on a clinical records audit pertaining to areas outlined in Table 5.

Table 5: Outline of SAFE clinical files audits

Subject of audit	Audit details*
a. Areas where family violence screening is mandated (antenatal and Maternal and Child Health) **b.** Areas where asking all patients about family violence because of high risk is indicated (case finding), for example mental health, drug and alcohol, sexual assault	Review relevant data in most recent record audits *or* Random sample of 50 records from each department/clinical area from patients/clients visits in the last 3 months
c. Patients who disclose family violence	Disclosures from a. and b. *or* Random sample of records where patients have disclosed family violence
d. Use of interpreters where a patient or caregiver's primary language is not English	Gathered as part of audit for a., b., and c.

Note: *General description only – some sites employed modifications of this (conducted in consultation with the SAFE Research Team) to suit their situation.

Five sites did *not* conduct any clinical files audits due to insufficient resources being available to undertake this activity within the SAFE Project timeframe. Most were small sites with minimal SHRFV staff allocation. Furthermore, they were health services who had not yet focused on the patient facing components of the SHRFV program so a clinical files audit would not have reflected the influence of the SHRFV program on these elements within the organisation.

Amongst the thirteen SAFE Sites that completed the clinical files audit the key findings are outlined below.

- Eleven provided antenatal services and of these only three (3/11) site audits found 80% or more of antenatal medical records had a family violence identification and screening tool completed. Mandatory routine screening for family violence is in accordance with Recommendation 96 of the Royal Commission into Family Violence.[6]
- In areas where asking all patients about family violence because of high risk is indicated (case-finding), three site audits (3/13) found *documentation* that this was being done in 80% or more of files. The areas, timeframe, and size of the audits for this work was tailored (in consultation with SAFE Research Team) to individual SAFE Sites to accommodate their size and services provided. Audited files typically came from Social Work, Mental Health Services, Drug and Alcohol Services, Sexual Assault and/or Emergency Departments and results for all service areas were combined.
- Where there was documentation that family violence had been disclosed:
  - 5/13 sites indicated there was routine documentation that standardised safety assessment, referrals and/or planned follow-up had been undertaken

DEFINITIONS

In the context of family violence[26]

Universal screening: applying standardised questions to all symptom free women using a set procedure.

Selective screening: screening women in high-risk groups (e.g., pregnant women).

Case-finding: asking questions if particular indicators are present.

  - o 7/13 sites indicated the needs of children, including unborn children, were routinely documented in identification, screening, risk assessment and safety planning
  - o 4/13 sites found ≥80% of disclosures had a documented offer of referral to services.
- Concerning the use of interpreters:
  - o for six sites (6/13) the use of interpreters was difficult to determine because there was little or no documentation indicating English was not the first language of the patient/client
  - o one site (1/13) did not conduct this component of the work
  - o of the remaining six sites, five (5/6) found there was *recorded* evidence that interpreters were routinely used where there was documentation in the file that this was needed.

Results from the clinical files audited revealed this area of practice contributed to sites' low performance on the *Identification and Response* domain and needs to be strengthened in accordance with the MARAM framework. For further discussion on this domain also see Low performing domains.

Many sites reported that the clinical files audit was/would have been useful – see Table 6 for SAFE Site Survey responses.

Table 6: SAFE Site Survey Results: Usefulness of clinical files audit

On a scale of 1 ('Not at all useful') to 5 ('Very useful')	1	2	3	4	5
How useful was, or would have been, the clinical files audit component of the SAFE Audit Tool?	0	0	2	4	6

However, they reported facing challenges conducting the work which included:

- it was time consuming
- not all sites had an Electronic Medical Record (EMR) system so could not run reports to gather data
- in some areas/departments reading through case file notes (sometimes handwritten) was needed and this made the audit process longer, more difficult, and open to oversights and interpretation
- some areas were only recording *disclosures*, so it is possible that patients were being asked about family violence but unless there was a disclosure it was not being documented in the clinical record
- a proportion of the recorded disclosures were cases where the patient/client was the perpetrator and there were not well-defined response procedures for this, nor clear expectation as to how to consider these situations in the SAFE Tool.

As one SAFE Site Survey participant said:

> ***Instructions about the clinical file audit could be clearer, and with response options that take into consideration that the client may be the perpetrator of violence. Inclusion of perpetrator identification and response was low throughout the tool.***
>
> **(SAFE Site Survey participant)**

In addition, sites had difficulty understanding the difference between *screening* and *case-finding*,[26] and areas audited varied between sites due to different patient cohorts and service provisions at health services.

> ***[Resourcing to repeat the SAFE Audit Tool would need to account for] the Clinical file audits, which are a valuable part of the process but labour intensive, even despite the introduction of the EMR in our health service since the completion of SAFE in our health service.***
>
> **(SAFE Site Survey participant)**

Special projects

In conducting the SAFE Project, a number of special/noteworthy projects and activities undertaken by SHRFV teams, but not specifically captured in the SAFE Tool, came to the fore. Whilst acknowledging the following is not a definitive list, some of the work is highlighted below.

SPECIAL PROJECTS

- Finding creative ways to communicate messaging around family violence and available resources (e.g., using purpose built visual displays, inviting guest speakers to the health service's Annual General Meeting, producing short videos)
- Conducting research projects to inform family violence work (initiated in large and supported health services)
- Investing in a special project (e.g., to assist Aboriginal women who experience family violence)
- Developing strategies to assist family members of patients who disclose family violence (e.g., women whose partner (patient/client) uses violence)
- Conducting special events to foster awareness raising, profile building and the strengthening of collaborative relationships with relevant services and organisations (e.g., Forums.)

Individual SAFE Site Reports

Eighteen confidential SAFE Site Reports were provided to each participating site's Chief Executive Officer. They were tailored to each health service and included:

- presentation and discussion of SAFE Tool results
- background information concerning the SHRFV program at the site, e.g., commencement of the initiative, SHRFV responsibilities, resourcing, and staff allocation
- highlights of the SHRFV program at the site
- recommendations for the health service.

Each site was provided with recommendations that listed priority areas to sustain or improve the family violence response and for incorporation into the organisation's family violence planning and strategy.

These reports were important in:

- drawing attention to family violence program work and the SHRFV teams
- providing advocacy for SHRFV and resourcing of the program
- highlighting achievements
- providing potential direction for sustaining and future development of SHRFV.

The SAFE Research Team received feedback that the reports were well received both by the SHRFV teams and the Chief Executive Officers.

> ***[We] are very pleased we submitted EOIs [Expressions of Interest] to be part of SAFE as the resultant [SAFE Site] Report is a great summary and overview of key achievements and areas for further work. I also like the emphasis on what the health service needs to do in order to sustain this important work.***
> **(Comment via engagement with site)**

Recommendations from these reports are summarised and synthesised in the 'Discussion' and 'Recommendations' sections of this report to preserve anonymity.

Findings in context: Experience of participating

The experience of participating in the SAFE Project were explored through the following:

- Post-Audit SAFE Site Meetings
- Ongoing engagement (emails and telephone calls) with the SAFE Research Team, including as part of the Consultation Process conducted to review SAFE Tool responses and evidence
- SAFE Site Survey – two thirds of eligible health services (12/18) responded to this online survey. The survey was conducted towards the end of the SAFE Project and many sites had experienced SHRFV staff changes since the SAFE Tool was implemented.

We synthesised findings from each of these sources to consider the experience of participating in the SAFE Project from the perspective of:

- The SAFE Tool
- Administering the SAFE Tool
- The impact of the SAFE Project.

The SAFE Tool

SAFE Sites were positive about the SAFE Tool. Results from the SAFE Site Survey were that:

- all (12/12) respondents felt the SAFE Audit Tool was comprehensive
- most (10/12) agreed it was easy to navigate
- the majority (8/12) felt the SAFE Audit Tool *Items* and corresponding *Measurement notes* were clear, two (2/12) were not sure.

See Appendix 7 for further details of the SAFE Site Survey results. To illustrate these findings, two survey participants comments follow.

> ***It [the SAFE Tool] was a very comprehensive tool which was quite easy to navigate once you got the time to dedicate to it.***
> **(SAFE Site Survey participant)**

> ***More detail in the measurement notes [would be good] as some were unclear and open to interpretation which could affect consistency in response. Some examples may also be useful to provide clarity.***
> **(SAFE Site Survey participant)**

Similar sentiments were expressed at Post-Audit Meetings with typical comments being that the SAFE Tool was:

> ***'easy to use'; 'user-friendly'; 'easy to navigate'; 'comprehensive'***
> **(typical comments expressed at Post-Audit Meetings)**

Administering the SAFE Tool

Some SAFE Sites found administering the SAFE Tool more challenging than others and the SAFE Research Team noted that this was more likely when:

- the SHRFV program was positioned with Human Resources/People and Culture
- SHRFV staff resourcing/availability was low
- the person administering the SAFE Tool was new to the organisation's SHRFV team and/or a non-clinical staff member
- staff responsible for administering the SAFE Tool changed during the audit process.

In response, where it was needed, and possible, the SAFE Research Team engaged in a more extensive consultation process with sites to discuss and review the SAFE Tool responses and corresponding evidence.

Further to this, in small sites where there was limited SHRFV allocation (if any), staff were more affected by administering the SAFE Tool – the time taken to administer the Tool was taking away from other tasks they were responsible for, including family violence work itself.

All the SAFE Site Survey participants (12/12) reported that communication with the SAFE Research Team was accessible and timely (see Appendix 7 for further details).

> ***...the tool was very user friendly and the team [SAFE Research Team] were incredibly supportive.***
> **(SAFE Site Survey participant)**

Impact of the SAFE Project

Participation in the SAFE Project (completing the SAFE Tool, engaging in a consultation process with the SAFE Research Team, and receiving a SAFE Site Report) impacted SAFE Sites at a number of levels. Illustrative quotes are from SAFE Site Survey participants.

- ***SHRFV Staff:*** for some sites, reflecting on the SHRFV Team's work provided them with the opportunity to celebrate their achievements and take pride in the success of the work that had been undertaken (although still acknowledging opportunities for improvement existed). This was important given the challenges faced with implementing system wide changes to strengthen responses to family violence within (sometimes very large) health services. These challenges were heightened during the COVID pandemic.
- ***SHRFV implementation level:*** SAFE Project participation offered insights into the family violence work within individual health services. This included highlighting the strengths and weaknesses, which in turn provided directions for future work, and in conjunction with the Site Report Recommendations also contributed to the development of Action Plans at the sites.

> ***The SAFE recommendations have been very useful in highlighting the strengths and weakness within our health service. These findings and recommendations have been presented to our Executive governance group and incorporated into our MARAM alignment and Action Plan.***
>
> **(SAFE Site Survey participant)**

- ***Organisation level:*** the SAFE Project helped raise the profile of family violence work within organisations, and the important role of SHRFV staff in conducting this work. Being part of an independent process and having a tangible (externally written) Site Report with recommendations was important – this could be presented to health service executives and used for advocating for family violence work within the organisation. One of the more immediate examples was where organisations with maternity services responded to initiate antenatal family violence screening where this was not being routinely performed.

> ***The SAFE audit provided a fantastic snapshot … [including an outline] of where the organisation is doing well implementing the SHRFV project, and where we need to focus resources moving forward. [It also] … provided a summary [we could] … present to our executive and working group to highlight how the SHRFV project is having an impact across the organisation.***
>
> **(SAFE Site Survey participant)**

> ***We sent the audit to the executive before we submitted it and the low score for antenatal screen prompted them to ask why we had not implemented it. This started a discussion with the director which led to the quality team and education team all coming on board for training and education for midwives.***
>
> **(SAFE Site Survey participant)**

Strengths and Limitations of the SAFE Project

The SAFE Project had both strengths and limitations.

Strengths

- Project was evidence based and drew on work being conducted by the New Zealand Ministry of Health *Violence Intervention Programme* (VIP) which has been ongoing since 2004.[11, 15]
- The number, range, and diversity of health services who participated in the SAFE Project.
- Use of a purpose designed System Audit Tool (SAFE Tool) based on international best practice and developed by researchers experienced in the field, in consultation with a diverse group of experts and stakeholders.
- It was piloted prior to full rollout.
- Sites were eager to participate, and the project was conducted with the support of health service SHRFV teams and executive leadership.

Limitations

- The reliance on a self-report method of auditing is likely to introduce errors at an individual site level, and inconsistencies across participating sites. To help overcome this, a careful review of all sites responses and evidence was conducted in consultation with site representatives. Experience in New Zealand showed that when self-audits were undertaken there was over-reporting by sites.[27] However, we noted this did not happen across the board.
- To maintain anonymity, results were not presented according to speciality, size or location of sites which presented some limitations on conclusions and recommendations particular to these settings. This may have disadvantaged smaller sites who were being compared to larger, better resourced, health services.
- The time interval between (a) commencement of the SHRFV program (ranging between 2014 and 2018), and (b) SAFE Tool completion, varied between sites – which meant some SAFE Sites had been working on implementing the SHRFV program for longer time periods than others.
- Health services did not complete the SAFE Tool at the same time with some Phase 3 sites completing their SAFE Tool immediately prior to MARAM and Information Sharing Scheme prescription (19 April 2021)[24] and their SAFE scores may have benefited from the focus and intensity of work being undertaken to align with these legislative reforms.

Discussion

Discussion

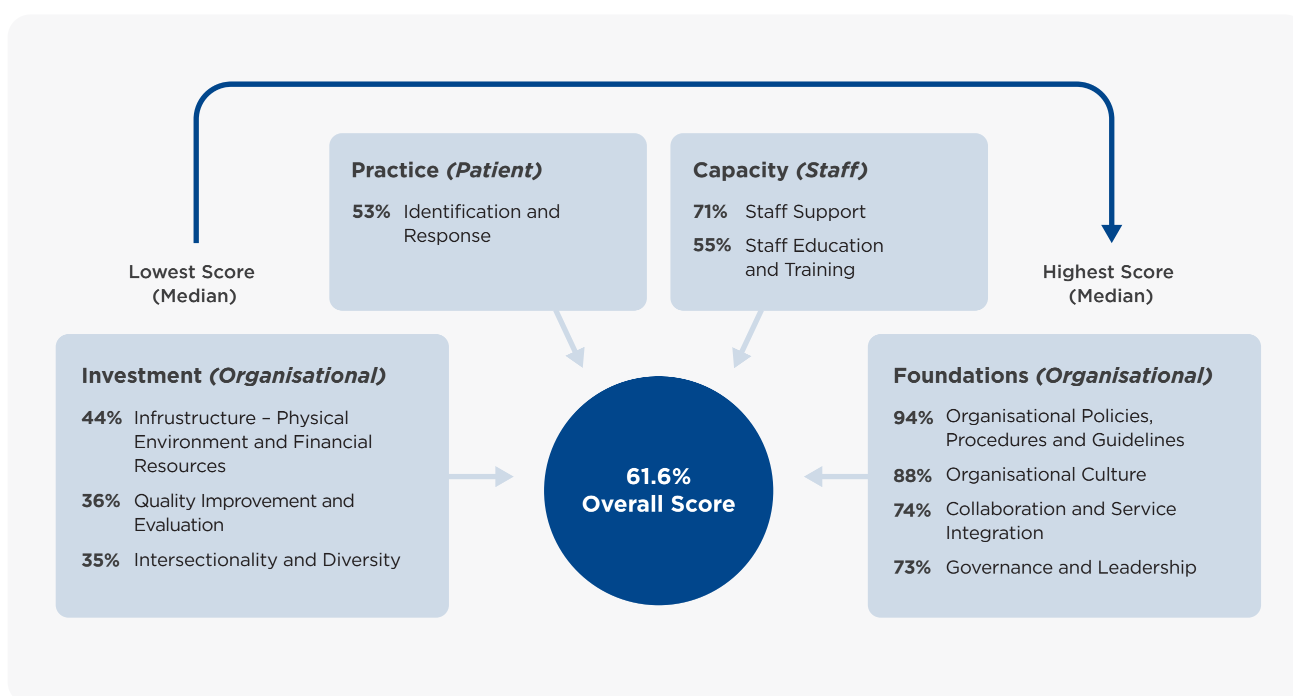
The successful administration of the SAFE Tool at eighteen health services has provided a snapshot as to how these diverse organisations are implementing system change at patient, staff, and organisational levels through the SHRFV program. Although the findings cannot be considered to represent state-wide performance, they do provide insight into family violence work within health services from which implications and recommendations can be drawn.

Overall, it is clear that the SHRFV program has enhanced the capacity of SAFE Sites in their ability and readiness to identify and respond to family violence – recognising that the SHRFV model is one family violence program of work model and family violence work in health services is broader than SHRFV.

SHRFV implementation was being undertaken by dedicated teams and people committed to improving the lives of women and children affected by family violence and ensuring their organisation is a safe place for staff to work and victim survivors to seek help. Sites and their SHRFV teams are to be congratulated on their achievements in the ongoing implementation of a whole-of-organisation response to family violence; however, there is still work to be done.

The ranking of the SAFE Domains according to performance (see Figure 17) largely aligned with the SHRFV program key directions, strategies, and resources.

Figure 17: Ranking of SAFE Domains (based on median scores)



The SHRFV program has had a focus on laying the foundations and building capacity for family violence identification and response work through implementing organisational policies and procedures, fostering strong organisational culture, governance and leadership, collaboration and staff support and training. It is acknowledged that these are the essential building blocks, while addressing workforce and staff facing components of SHRFV has engaged staff in a shared understanding of family violence and recognised that staff can be victim survivors. However, health services now need to bolster the *patient facing* components of the work and strengthen identification and responses to family violence – the latter may present particular challenges for health services in small communities (regional and rural) where there are potentially issues around anonymity and confidentiality.

To achieve a mature, sustainable, and embedded program of family violence work, health services need to invest. In so doing they will help ensure this vital work is critiqued (through auditing and evaluation), responsive to change and improvements, and is accessible to all.

The performance rankings above (see Figure 17 p.46) not only allowed the SAFE Research Team to explore where sites are doing well, it provides the framework to consider what are the enablers for system change to address family violence in health services, and where the challenges lie. It also provides a structure for recommendations at the practice level and government level, for the SAFE Tool (as a mechanism for effective auditing and embedding family violence work), and future work to improve outcomes.

Enablers

Through synthesis of the data gathered via the 'SAFE Audit', and the 'Experience of SAFE Tool and participation' (including extensive engagement with the SAFE Sites – outlined in Figure 2 p.16), the SAFE Project provided insights into the key enablers that help make system changes within health services to address family violence. These are outlined in Figure 18 below, falling under three broad categories – the SHRFV program, staffing arrangements, and funding.

Importantly, the enablers identified here largely mirror health service strengths, i.e., areas of higher performance (as outlined in Figure 17 p.46), and how these were most successfully achieved. As such they are not definitive but reflective of the SAFE Project findings. Future auditing work will potentially provide additional insights that will further inform understandings of enablers of system change within health services.

SHRFV

Within the SHRFV program, resources, leadership, organisational structure, strong collaborative relationships and quality improvement and evaluation strategies were identified as key enablers of a whole of organisation approach to family violence work in the health service setting.

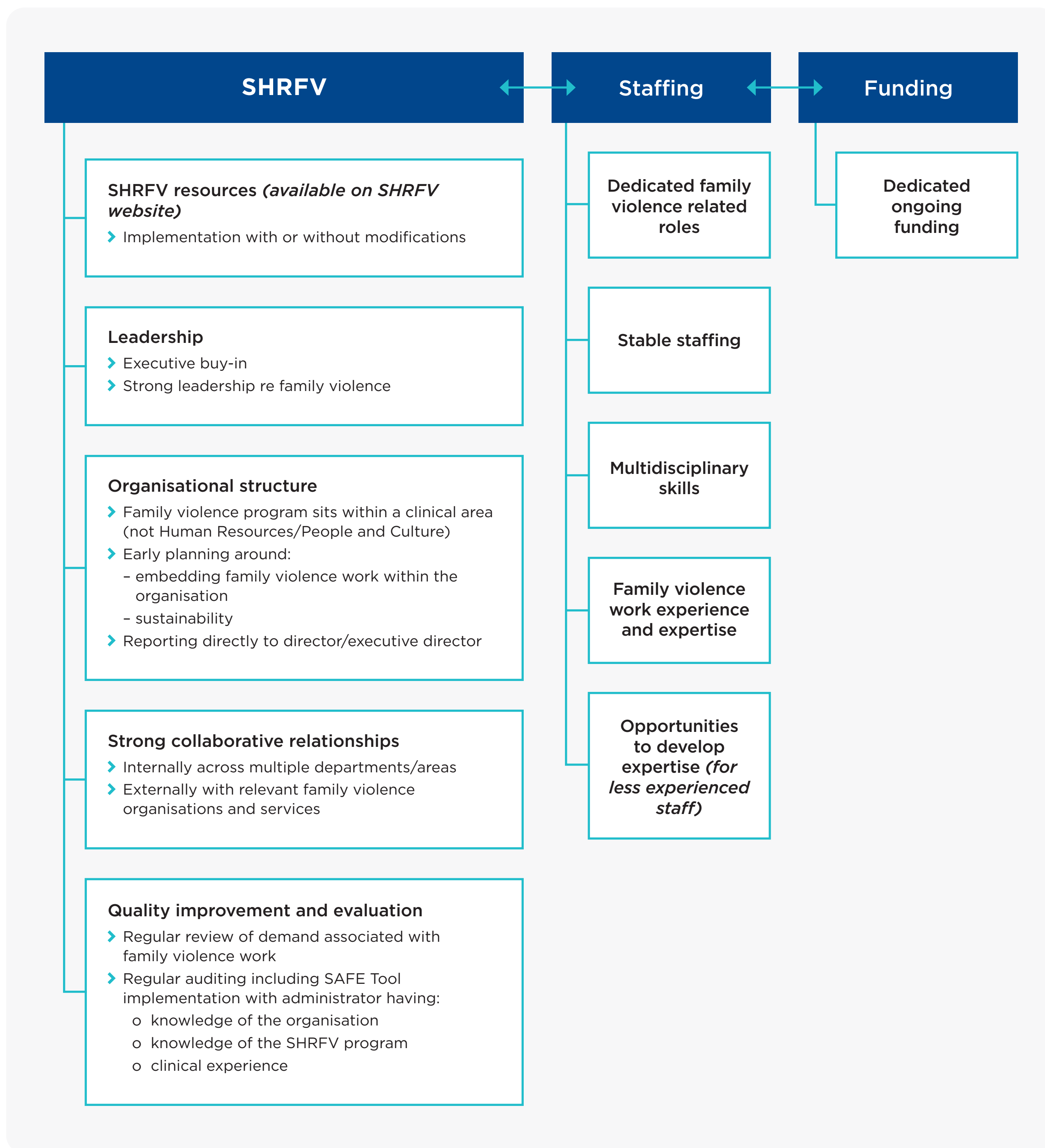
A key facilitator to SHRFV implementation at health services, as indicated by sites SAFE Tool responses, was the SHRFV resources available (at not cost) to *all* sites via the SHRFV websites (these also providing examples for resource development outside of Victoria).[4] This extensive suite of material, developed by the state-wide lead organisation (the Women's), includes project management resources, training material, workplace support resources, sample policies and procedures, and communications material.[4] Additional support is also provided to sites through state-wide (the Women's) and sector leadership, including Communities of Practice in metropolitan (Lead: the Women's) and rural and regional areas (Lead: Bendigo Health).

There was an observable difference between SHRFV implementation versus *sustainable* SHRFV implementation, the latter being accomplished via application of well thought through governance structures with direct reporting to senior executive in order to influence and achieve change. Those sites who considered and prioritised sustainability at the *commencement* of SHRFV implementation benefitted from this investment with the resulting family violence work being more strongly embedded within their organisation. Building or maintaining solid governance and leadership and ensuring ongoing commitment to maintaining family violence as an area of focus with future strategic planning will be important.

Strong collaborative relationships benefit health services responses to family violence. Internally they allow for the delivery of a multidisciplinary approach to responding to family violence within health services, engaging multiple areas and raising awareness. Externally they facilitate referral pathways and solidify the role of health services in the care of people affected by family violence.

Finally, those health services who had strong quality improvement and evaluation strategies that responded to family violence demand and auditing processes by skilled staff enabled the family violence program of work.

Figure 18: Key Enablers of system change within health service to address family violence as highlighted by the SAFE Project



Staffing and Funding

Appropriate staffing was also found to be a key enabler. Sites need dedicated SHRFV Project Leads/Officers to facilitate the capacity for innovation, responding to family violence reform, education and training, quality improvement and evaluation. Having stable, multidisciplinary skilled teams with expertise and experience is also important. Further, providing opportunities to develop staff skills and expertise is crucial for sustainability. SAFE Sites and teams that drew on expertise and experiences in other related and transferable work (in particular elder abuse) started at a higher baseline.

However, to support this work, strategies for funding of the work are important.

Challenges

All health services faced some challenges in sustaining the program of work due to funding uncertainty, and there is a continuum of positions about how family violence work is funded which health services and SHRFV staff were wrestling with. At one end separately funding SHRFV work as a 'special project' helps ensure this important work is undertaken by health services – i.e. that work is planned, implemented, evaluated and maintained. At the other, embedding family violence work and practice within a health service, and demonstrating a commitment to it being 'usual practice', requires the organisation to commit to appropriate levels of funding and resourcing. What SHRFV teams desperately want is certainty around funding, which needs to be accompanied by sustainability planning.

The SAFE Tool was administered across a wide range of health services that had different approaches to SHRFV implementation. It emerged that in implementing the SHRFV program, size of sites was more of an indication of similarity (small, medium, and large), rather than location (metropolitan versus regional and rural). This was exemplified in the challenges and opportunities sites faced. While acknowledging all sites are unique, bigger sites were undertaking system change within organisations where there were large numbers of staff to engage and train, within complex organisations providing many and diverse services. As such there were multiple and competing demands on the health service and its leadership group. SHRFV teams were navigating these challenges as they implemented the SHRFV program. However, the teams frequently included people with significant family violence expertise and/or had the opportunity to focus on responses to family violence within their organisation and further build experience.

At small sites, SHRFV implementation was being undertaken with less resources – funding and frequently family violence expertise. SHRFV was often only one (sometimes small) component of people's many varied workplace responsibilities and consequently there was less time to focus on responses to family violence and build specialist skills in this area. Nonetheless with fewer staff, less service provision, and a flattened organisational structure, SHRFV teams were able to oversee significant changes and had greater potential to train a sizeable proportion of health service staff.

Sites are facing challenges lifting performance on *Identification and Response*, the sole Patient Domain. These are intensified by the fact that patient facing components rely on teams of clinical staff undertaking and documenting this work. Whilst the MARAM Framework will inform this, health services need to build staff capacity, capability, and confidence. Furthermore, organisations need to consider identification and response in light of the increased move to telehealth (and likely to be a significant feature of service provision for rural and regional settings in the future), which has been expanded due to the COVID-19 pandemic.

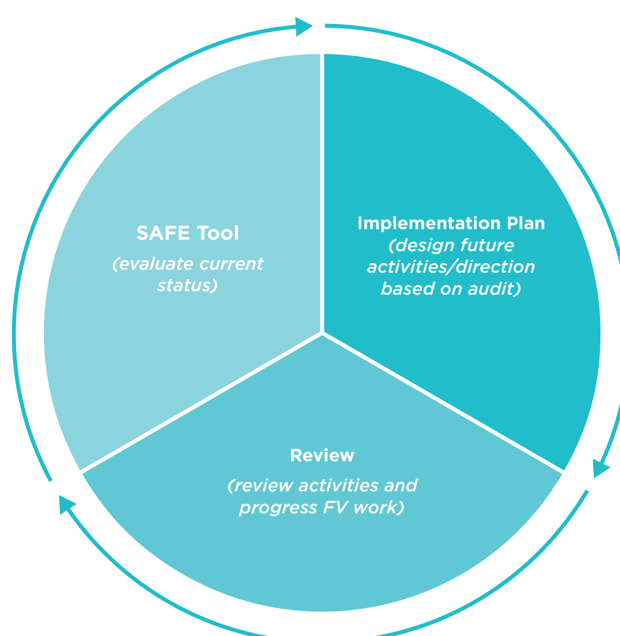
The very low performance on the domain *Intersectionality and Diversity* needs urgent attention. In describing 'Principles of Intersectionality' Hankivsky[28 p.8] provides a framework to guide 'doing' intersectionality informed work which includes:

- Intersecting categories
- Multi-level analysis
- Power
- Reflexivity
- Time and space
- Diverse knowledges
- Social justice and equity.

The development of intersectionality guides and a relevant capability building framework would help inform health services undertake this work.

Across all sites, a suite of actions to strengthen the strategic and continuous monitoring of the health service's response to family violence, thereby ensuring service effectiveness in achieving family violence systems change, will contribute to embedding and sustaining the program of work. This highlights the need for regular auditing if health services are to embed the SHRFV program, and family violence work more broadly, into their organisation. The SAFE Tool offers a pathway for the embedding journey as shown in Figure 19.

Figure 19: Using the SAFE Tool to embed family violence work into organisations



Recommendations

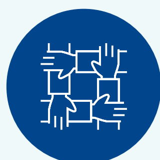
Recommendations for family violence practice for health services

Recommendations for family violence practice cover the three domain areas in the SAFE Tool (patient, staff and organisational) and mirror the areas needing more attention found by the SAFE Tool – see Figure 20.

Figure 20: Recommendations for family violence practice

Greater Investment

- Develop strategies to improve inclusivity and accessibility of the family violence program for diverse groups
- Undertake the SAFE Tool annually to provide quality assurance and feedback mechanisms
- Create safe confidential spaces and strategies across the health service and at home for community teams or telehealth services
- Commit to funding of a family violence role within the health service to ensure the program is sustained



Strengthen Practice

- Develop effective strategies to undertake family violence antenatal screening
- Implement identification, risk assessment and safety planning across all services where patients/clients are at high risk of family violence and ensure this is effectively documented, and information shared with other services
- Develop response to patients/clients who are perpetrators of family violence and a system to support this work

Build Capacity

- Develop strategies to implement and sustain Family Violence Clinical Champions (who support staff responding to family violence) and Contact Officers (who support staff who have experienced family violence) programs along with an evaluation plan
- Continue to build capacity through staff education/training including:
  - increasing reach and exploring options for expanding mandated family violence training where appropriate
  - providing opportunities for ongoing training and developing a mechanism for updating training

Maintain Foundations

- Strong '*Governance and Leadership*' and '*Organisational Policies, Procedures and Guidelines*'
- Activities that promote strong '*Organisational Culture*' concerning family violence and gender equity
- Ensure ongoing '*Collaboration and Service Integration*'

Develop Actions

- Development of a family violence program Action Plan from the SAFE Audit results to strengthen the strategic and continuous monitoring of the health service's response to family violence and inform system change

Recommendations for government

In recognition of the role government has in ensuring health services maintain and/or improve responses to family violence, the SAFE Project provides recommendations for government directed at both state and national levels – see Figure 21.

Figure 21: Recommendations for government

Victoria

- Fund annual implementation of the SAFE Tool at health services through the University of Melbourne and with associated health service and survivor governance
- Produce annual state-wide reports based on the SAFE Tool results
- Undertake an annual review, by the University of Melbourne, of the family violence Action Plans of each health service (in line with MARAM and Information Sharing)
- Review and change (where appropriate) the SAFE Tool *Indicators* (and corresponding *Measurement notes*) every three years to ensure alignment with policy directions and legislation

Nationally

- Adapt the SAFE Tool for national use
- Implement the national SAFE Tool and process across Australia
- Establish national standards for responding to family violence in health services
- Include family violence in The National Safety and Quality Health Service (NSQHS) Standards

Recommendations for the SAFE Tool

The SAFE Project provided an opportunity to review the SAFE Tool, in addition to its piloting prior to this project – in particular the wording and applicability of the *Items* and *Measure notes*, following widespread implementation experience across a diverse range of health services.

In general, the SAFE Tool was well received and completed by SAFE Sites, however, there are amendments which will improve the clarity, interpretation, applicability, and robustness. These have been based on the SAFE Research Team's experience, and feedback from the SAFE Sites, and broadly include:

- simplification and splitting of some of the complex *Items* with multifaceted *Measurement notes*
- greater clarification concerning *Items* that relied on clinical files audits
- removal/replacement of *Items* that are not uniformly applicable across sites
- rewording to ensure relevance of the Tool for future use
- create a SAFE Lite Tool tailored to small sites
- assist staff to develop skills in clinical audits.

> ***'The SAFE audit would require a short-term dedicated resource in order for it to be completed thoroughly and accurately. This is particularly in relation to the clinical file audits, which are a valuable part of the process but labour intensive.'***
>
> **SAFE Site Survey participant**

Recommendations for ongoing research and evaluation of family violence programs

A number of suggestions for future implementation of the SHRFV model arose out of the SAFE Project.

- *Investigate and evaluate implementation of SHRFV or other family violence program of work models.* SHRFV teams are keen to understand what implementation models are working well and not so well and consider how these could inform their own work. Furthermore, the SAFE Tool prompted SAFE Sites to think about how to implement specific change in new and/or difficult areas and wanted to discuss and learn how other health services have approached this work (with examples). At this mature point in the SHRFV implementation, and in the context of diminishing funding, this could be done by considering expanding the existing SHRFV Community of Practice to incorporate all Victorian SHRFV teams, metropolitan and rural regional, and promoting this as an avenue for raising questions and challenges and sharing of ideas and experiences.
- *Conduct a consultation process with smaller/ support health services around SHRFV implementation* and consider models that are suited to these settings. The challenges faced by these SHRFV teams are distinct – it is by partnering with them, and utilising their knowledge and experience, frameworks for sustainable family violence programs of work can be realised.

Conclusion

The administration of a purpose designed System Audit Tool (SAFE Tool) at eighteen heath services showed that sites are progressing system change within their organisations to address family violence at patient, staff and organisation levels and they should be congratulated on their achievements to date. However, there is still work to be done.

The ten domains of the SAFE Tool provide an insight as to how organisations were travelling with regard to the implementation of the SHRFV program. Health services were performing well on domains concerning the organisational foundations crucial in realising a whole-of-organisation response to family violence - *Policies, Procedures and Guidelines, Culture, Collaboration and Service Integration* and *Governance and Leadership*. They were building staff capacity through *Staff Support* and *Staff Education and Training*, however, the patient facing components of family violence *Identification and Response* need greater attention.

It is essential health services invest in family violence work and ensure it is embedded within the organisation through resource allocation (*Infrastructure – Physical Environment and Financial Resources*) and provide responses that are wide reaching and accessible by applying an *Intersectionality and Diversity* lens to family violence work.

To ensure family violence work is embedded within organisations, and *Quality Improvement and Evaluation* is undertaken, regular auditing with feedback is required. The SAFE Tool provides the vehicle for this.

Appendix 1: SAFE Tool

The SAFE Project has been informed by the New Zealand Family Violence Program Evaluation.[11, 15] The SAFE Tool was designed using a consultation method known as a Delphi process. This involved conducting surveys and a workshop, to gather opinions from diverse experts and stakeholders to arrive at group consensus on the optimal design and wording.[29] The experts included practitioners, managers, researchers, policy makers and representatives from the eighteen sites. The SAFE Tool was piloted at the Royal Women's Hospital in late 2019 and is provided to sites as a locked Excel data entry form, with weightings applied, ready for use.

The SAFE Tool comprises ten *Domains* (broad areas) and seventy-one *Indicators* (individual measurement items with accompanying measurement notes). *Domain* and *Indicator* weightings have been applied to reflect the importance and contribution of these elements within the SAFE Tool. As such, every *Indicator* has a weighted score, which when summed results in a *Domain Score,* and each *Domain* is weighted and summed to give an *Overall SAFE Audit Score* out of 100 percent.

	Domain	Definition	Weight	No. of Indicators
PATIENT	1. Identification, first line response, and follow-up	A standard identification and screening protocol and first line response approach to guide appropriate assessment, referral and follow-up when responding to family violence	19	13
STAFF	2. Staff education & training	Staff are trained to have a shared understanding of family violence, training is tailored to clinical staff, specialist staff, managers	10	7
	3. Staff support	Practical support for all staff to undertake their work to address family violence	9	6
ORGANISATIONAL	4. Organisational policies, procedures & guidelines	Up-to-date policies, procedures and guidelines support family violence first-line identification and response for patients and staff using a lifespan approach	9	6
	5. Governance & leadership	The health service demonstrates governance, leadership and investment in family violence program sustainability	11	7
	6. Intersectionality & diversity	The program is inclusive and accessible for diverse communities including people with lived experiences of family violence	8	7
	7. Collaboration & service integration	Internal and external collaboration throughout family violence program and practice	8	3
	8. Infrastructure – physical environment & financial resources	Infrastructure to support the family violence program – physically safe environment in which to seek help for family violence; a fully funded and allocated program supporting dedicated staff and resources	8	7
	9. Organisational culture	Organisational culture that demonstrates recognition of family violence and gender equity as an important issue for the health service	10	7
	10. Quality improvement & evaluation	Strategic and continuous monitoring with feedback to ensure service effectiveness is achieving its goal of systems change	8	8
Total			**100**	**71**

Appendix 2: Pre-Audit Meeting Agenda (example)

Meeting Agenda

System Audit Family violence Evaluation: SAFE Project

Stage 3

1. Overview of the project	Jean Cameron
2. Development of the System Audit Tool	Jean Cameron
3. System Audit Tool a. Data collection process and expectations	Heather McKay
4. Project timelines and partner support a. August 2020 to February 2021 b. Ethics approval - quality assurance c. Any questions or barriers d. Meeting to discuss results and reports	Jean Cameron
5. Other business	All

Appendix 3: The SAFE Tool Information Pack

Introduction

The SAFE Tool is a System Audit Tool that assesses health services systems and infrastructure response to family violence. Based on local and international best practice, the SAFE Tool was developed by researchers at the University of Melbourne and the Royal Women's Hospital in consultation with experts and relevant stakeholders across Australia.

The SAFE Tool comprises ten Domains (broad areas including one Patient Domain, two Staff Domains and seven Organisational Domains) each with accompanying *Indicators* (measurement items). It is provided to sites as a locked Excel data entry form ready for use. Within the form, built in weightings have been applied to each indicator and domain to reflect the importance and contribution of items; completion gives an Evaluation Result comprising ten *Domain Scores* and an *Overall Score* out of 100.

Implementing the SAFE Tool

Planning

To administer smooth implementation of the SAFE Tool we encourage you to have a strategy in place to direct your work. You may find it useful to consider the suggested approach outline below.

Planning for the SAFE Audit

	Activities to help plan your SAFE Internal Audit
1	Read through *The SAFE Information Pack* and understand SAFE Site responsibilities
2	Ensure ethics clearance has been achieved – *note that site Research and Human Research Ethics Committees are likely to consider the evaluation a Quality Assurance/Audit Project*
3	Establish a timeline
4	Know which staff will be part of the SAFE Audit and identify their roles and responsibilities
5	Ensure there is adequate resources and support for the SAFE Audit
6	Identify who will be responsible for returning the completed SAFE Audit Tool
7	Identify the Health Service Executive who will approve final SAFE Tool responses and accompanying letter of support
8	Determine who the SAFE Site Final Report will be sent to (in addition to the Chief Executive Officer)

Conducting the SAFE Audit

After planning, and communicating these details to the SAFE Site Team, you are ready to commence conducting the SAFE Audit Tool and we encourage you to have a strategy in place to direct your work. You may find if useful to consider the suggested approach outlined on p56.

Strategy for conducting the SAFE Audit using the SAFE Tool	
1	Familiarise yourself with the layout of the SAFE Tool: *understand how to navigate through the Tool and become acquainted with the contents on each screen*
2	Read through the SAFE Audit Tool *Indicators* and *Measurement notes* to familiarise yourself with requirements
3	Understand the specific requirements for the clinical files audit (Items 1.1, 1.2, 1.6, 1.7, 1.13 and 6.5 in the SAFE Tool). Please note: – a SAFE Clinical Files Audit Tool (excel format) is provided by the SAFE Research Team for use as a basis for gathering this data – SAFE Sites will need to determine where and how to undertake the clinical files audits – discuss with SAFE Research Team as appropriate
4	Against each Indicator, determine how data will be obtained as per the SAFE Audit Tool measurement notes – decide which health service department corresponds to the indicator and identify the staff member(s) you will need to communicate with to obtain the data/evidence required
5	Determine where you need assistance and identify who you might approach to ask for help
6	Gather the evidence required
7	Respond to each item in the SAFE Audit Tool and provide accompanying evidence
8	Complete the '*Form complete by*' and '*Date*' details on the '*Evaluation Results*' screen
9	Provide completed SAFE Audit Tool to the appropriate health service executive for approval and letter of support
10	Return completed SAFE Audit Tool to the SAFE Research Team (email to the SAFE Project Manager)

Completing the SAFE Tool

The SAFE Tool has an '*Instruction and Help*' screen which will assist you with the practical aspects of completing the Tool.

You will need to provide evidence to support each of your 'Yes' responses – there are *measurement notes* for each indicator, and these will allow you to identify what evidence you need to collect. Measurement notes are outlined within the SAFE Tool and can be accessed two ways:

- they appear in the worksheet when you hover your mouse over cells with the red triangles next to each indicator (see below)

	Item	Response	Please provide evidence	Item points
1	80% of staff are trained in a shared understanding of FV and FV policies and procedures at orientation, or within the first 12 months of employment?			
2	All clinical staff are mandated to attend best practice FV training on inquiry, risk assessment, referral and follow-up?			1.500

Evidence must show FV / FV program is included (specified) in the orientation program agenda or material (e.g. mentioned within a presentation, or part of online training). To qualify for a 'yes', there must be documentation that over the last year, 80% of new staff complete this training (e.g. from HR sign-off).

- via the 'Measurement Notes Summary Page' which is the last screen in the SAFE Tool – this provides a list of all the indictors and measurement notes and can be printed out for your convenience (see below).

adership	1	FV is included in the strategic plan?	Mention of FV and/or FV program in the health service's strategic plan.
	2	FV has a standalone strategy and/or operational plan with key performance indicators and evaluation framework?	To qualify for 'yes', a written document must exist and include key perfc service's executive and board.
	3	FV is included in health service's health planning?	Mention of FV in a review of the health service's documentation concer

Some items in the SAFE Tool also have links to examples or references which may help you (see below) – you may need to copy and paste the link into you browser as health services cyber security measures may prevent direct access from the SAFE Tool.

	Item	Response	Please provide evidence	Item points	Your points	Links to examples/references
1	80% of staff are trained in a shared understanding of FV and FV policies and procedures at orientation, or within the first 12 months of employment?			1.000	0.000	https://thewomens.r.worldssl.net/images/uploads/general-downloads/shrfv/SHRFV_Module_one_with_embedded_video_Updated_LV.pptx
2	All clinical staff are mandated to attend best practice FV training on inquiry, risk assessment, referral and follow-up?			1.500	0.000	https://thewomens.r.worldssl.net/images/uploads/general-downloads/shrfv/SHRFV_Combined_Module_One_Two_training_with_embedded_video_Updated_LV.pptx

Recording Evidence

Against each item is a box for you to provide a summary of the evidence you gathered – this must be completed if you are responding with a 'Yes'. We recommend you also keep your own evidence folder which you do not have to submit with your completed SAFE Tool but can be referred to if required.

Conducting clinical files audit

A small number of items require you to conduct a Clinical files Audit – these are outlined in the table below. You will need to plan how you will conduct this component of the work and the SAFE Research Team will provide you with a SAFE Clinical Files Audit Tool in excel format which you can use as a basis for gathering this data.

Item	Description Measurement Note
1.1	Where screening is mandated (e.g., antenatal clinics), 80% of medical records have a FV identification and screening tool completed (based on a random sample of charts)?
	Review relevant data in most recent record audit or conduct a specific one (random sample of 50 records from each department/clinical area (e.g., antenatal) retrieved and reviewed for patients/clients who have visited the clinic over the last 3 months). If ≥ 80% in each designated service then it is a 'yes'. If health service does not offer services in areas where universal screening is mandated then respond with not applicable.
1.2	In areas/departments (e.g., mental health, drug and alcohol, sexual assault) where asking all patients about FV because of high risk is indicated (case finding), 80% of medical records include documentation of asking about FV (based on a random sample of charts)?
	Review relevant data in most recent record audits, or conduct a specific one (random sample of 50 records per area/department retrieved and reviewed for patients/clients who have visited the relevant health service areas (e.g., 50 records from each of mental health, drug and alcohol, sexual assault) over the last 3 months). If ≥ 80% in each designated service then it is a 'yes'. If health service does not offer services in areas where high risk FV screening is indicated because of high risk of FV, respond with not applicable.
1.6	Standardised safety assessment, referrals and/or planned follow-up are recorded for all patients/clients who disclose FV (based on a random sample of charts)?
	This is evidenced by a spot record audit (50 patients/clients in total) of persons receiving routine enquiry and/or disclosing FV.
1.7	The needs of children (including unborn) are documented in identification, screening, risk assessment and safety planning?
	This is evidenced by a spot record audit (50 patients/clients in total) of patients/clients receiving routine enquiry and/or disclosing FV followed by risk assessment and safety planning.
1.13	Documented offer of referral rates to appropriate services for patients disclosing FV are at least 80%?
	As evidenced by 80% of patient/clients disclosing FV are offered a referral to a specialised service (e.g., social worker) or agency (e.g., Safe Steps) on record audits.
6.5	There is documentation of interpreter use with patients/clients?
	To qualify for a 'yes' there must be evidence in the clinical record, that an approved interpreter is used when the patient or caregiver's primary language is not English. It is not a 'yes' if the interpreter is related to or a friend of the victim or caregiver.

FAQs on the SAFE Tool

Q. Do I need to provide evidence against every item with a 'Yes' response?

Yes, you need to provide evidence for *all* 'yes' responses so show why this response was submitted.

Q. What do I do if I do not think the item is relevant to my health service?

A small number of items in the SAFE Tool have a 'N/A' (not applicable) response option which should cover items that are not relevant to every health service. If you think there are others, please contact the SAFE Research Team for advice.

Q. Where indicators ask for topics/items that are positioned with training material or documents can I just provide name of material or document as evidence, or do I need to provide more details?

In these cases, you need to provide more details than just the name of the training material or document – this could include heading or section names, slide number, or page numbers, or brief description of how the topic is covered. For example, '<Name of Health Service Document/Policy/Procedure> - Section 3 <title of this section>'.

Q. Does the evidence provided need to cover all aspects of the measurement notes?

Yes, for some items the measurement notes are multidimensional, and you need to include evidence that covers each aspect being asked about. For example, if the measurement notes state *'a resource list is available ... and to qualify for a 'yes' there must be evidence that the list has been review within the last two years'* you need to say where the list is and when it was reviewed.

Q. How do I respond if I find the health service is almost there but not completely?

Response options on the SAFE Audit Tool are generally 'Yes' or 'No'. You may find your health service almost reaches a 'yes' but not quite (for example 73% of staff are trained in a shared understanding of FV and FV policies and procedures at orientation, or within the first 12 months of employment instead of the required 80%) – in these situations you should respond with 'No', but in the evidence notes you can highlight that you are *almost there.* Remember the Tool is aspirational and a 'No' response will highlight where future developments and enhancement priorities are required.

The SAFE Tool Results

Indicator and *Domain* weightings are applied to reflect the importance and contribution of these elements within the Tool. As such:

- every Indicator within each Domain has a weighted score which, when summed, results in a *Domain Score* (converted to a *Domain Percentage Score*)
- each Domain is weighted and summed to give an *Overall Score* out of 100 percent.

As you complete the SAFE Tool your results will be automatically calculated, and you will be able to see this instantly.

Returning completed SAFE Tool

Review the ‘Evaluation Results’ page and enter your name and date

Arrange for an accompanying letter from a health service executive which states that the results have been approved by that person and are accurate to the best of their knowledge

Save the file with your health service name and date in the title and email, with accompanying letter, to SAFE Project Manager

Next Steps

After completing the SAFE Tool, it is important that you think about your SAFE Audit Results:

- Recognises and celebrate achievements
- Consider priorities for quality improvement and actions that can be undertaken by the health service to inform the next stages of the SAFE Evaluation

Thank you for your work in completing the SAFE Tool

Note: this Document was informed by the New Zealand Family Violence Program Evaluation[15]

Appendix 4: Post-Audit Agenda and Discussion Guide

Example from Stage 3

Post audit meeting with SAFE Sites: <site>

Scheduled Time: <time and date>

The purposes are to:

- Confirm level of SHRFV resourcing at the time of audit for *<site>*
- Seek feedback on participation in the SAFE Project and the usability of the Audit Tool
- Consider the overall preliminary SAFE audit results
- Discuss any issues with responses/evidence provided that require follow up
- Identify the priorities for improvement at the site to inform the final report

Prior to the meeting:

- The draft SAFE results will be provided
- This agenda for the meeting is provided below

Who should be at the meeting:

- SAFE Site Lead and any others involved in the internal auditing process as determined by the site

Agenda for the meeting:

1. **An overview of the SHRFV program at <*site*>**
   a. Staffing
   b. Time involved in SHRFV
   c. The focus of SHRFV at *<site>*

2. **The experience of participation in the SAFE project in regard to:**
   a. Can you describe your experience of using the SAFE Tool (e.g., ease of navigation; getting scores in real time; impact on SHRFV planning).
   b. Can you tell us about whether you think the SAFE Tool is comprehensive (e.g., any feedback on the domains and items covered; any addition or subtraction of items or domains).
   c. How would you describe the effectiveness of the measurement notes (e.g., clarity, any difficulties encountered in finding or understanding the directions provided)?
   d. Can you tell us about the evidence gathering process including the clinical files audit (e.g., what were the challenges, what was straightforward, what would you change).
   e. How would you describe your experience of participating in the SAFE Project and the implications for your organisation?

3. **The overall site SAFE result for <*site*>**
   a. Does the result reflect your expectations?
   b. What do you think have been key challenges at the site?

4. **The strengths and weaknesses**
   a. What are the key areas of achievement? What is the site doing well?
   b. What are the site's key areas for improvement in the context of the organisation's current priorities?
   c. Can you describe how the areas for improvement will be actioned at your site?
   d. How does this result influence your planning for the next 12 months?

Appendix 5: SAFE Site Survey

Introduction

Thank you for your contribution to the System Audit Family violence Evaluation (SAFE) Project through your health services participation in this work.

You will recall that the SAFE Project aims to develop and implement a robust initiative using a System Audit Tool (SAFE Audit Tool) to build the evidence base for how health services can effectively implement system change to reduce the burden of ill health associated with family violence on patients, children and hospital staff.

This short online survey (taking approximately five minutes to complete) is being conducted to investigate sites experiences of participating in the SAFE Project. We would appreciate it if *only one representative from your site completed the questions*, collaborating with others from your organisation if/where appropriate.

We understand that staffing changes mean your experience of participating in the SAFE Project may be limited, however, we would appreciate it if you responded where you can. If you feel you are unable to answer a question, or would prefer not to answer, please leave it blank and move to the next one.

The survey provides an opportunity to give feedback to the SAFE Research Team on the SAFE Audit Tool and administering it at your health service. There are also some context questions at the end.

Responses will be anonymous. Answers to fixed choice questions will be presented as aggregate results. Responses to open ended questions with written replies will be analysed, and we may use unidentified quotes in reports, publications, and presentations.

The SAFE Project, led by Professor Kelsey Hegarty, is being conducted by the Royal Women's Hospital and the University of Melbourne with funding from the Collier Charitable Fund.

If you have any questions about the SAFE Project or this survey, please contact Heather McKay (SAFE Research Fellow) via email: Heather.McKay@thewomens.org.au

Question: **How much time, in days, did you spend: (if more than one person was involved please provide the total amount of time i.e. in people days)**

(a)…**gathering evidence and completing the SAFE Audit Tool EXCLUDING the clinical files audit component?**

(b)…**conducting the SAFE clinical files audit?** (if your site did not undertake any clinical files audit please leave the question unanswered and move to the one)

Question: **Please rate the extent to which you think each of the following statement applies: (please mark one response for each statement)**

	Strongly disagree	*Disagree*	*Not sure*	*Agree*	*Strongly agree*
a) The SAFE Audit Tool was comprehensive	○	○	○	○	○
b) The SAFE Audit Tool was easy to navigate	○	○	○	○	○
c) The SAFE Audit Tool 'Items' and corresponding 'Measurement notes' were clear	○	○	○	○	○
d) SAFE Research Team communication was accessible and timely	○	○	○	○	○

Question: **On a scale of 1 ('Not at all useful') to 5 ('Very useful'): (please mark one response only)**

	Not at all useful 1	*2*	*3*	*4*	*Very useful 5*
How useful was, or would have been, the clinical files audit component of the SAFE Audit Tool?	○	○	○	○	○

Question: **What impact, if any, has conducting the SAFE Audit had on:**

(a) your health service?

(b) the Strengthening Hospital Response to Family Violence (SHRFV) program at your health service?

(c) family violence planning within your health service?

Question: **How could we improve the SAFE Audit Tool - this could be in regard to navigation, layout, instruction or content etc?**

Question: **What level of resourcing would be required to repeat the SAFE Audit Tool at your health service?**

***Question*:** **Is there anything else you would like to say about the SAFE Audit Tool and/or participating the SAFE project?**

We would like to give you the opportunity to reflect more broadly on implementation of the Strengthening Hospital Responses to Family Violence (SHRFV) initiative.

Question: **In relation to implementation of SHRFV at your site:**

(a) what has worked well?

(b) what has not worked so well?

Question: **What suggestions do you have for improving the implementation of SHRFV?**

We thank you for your time spent taking this survey.

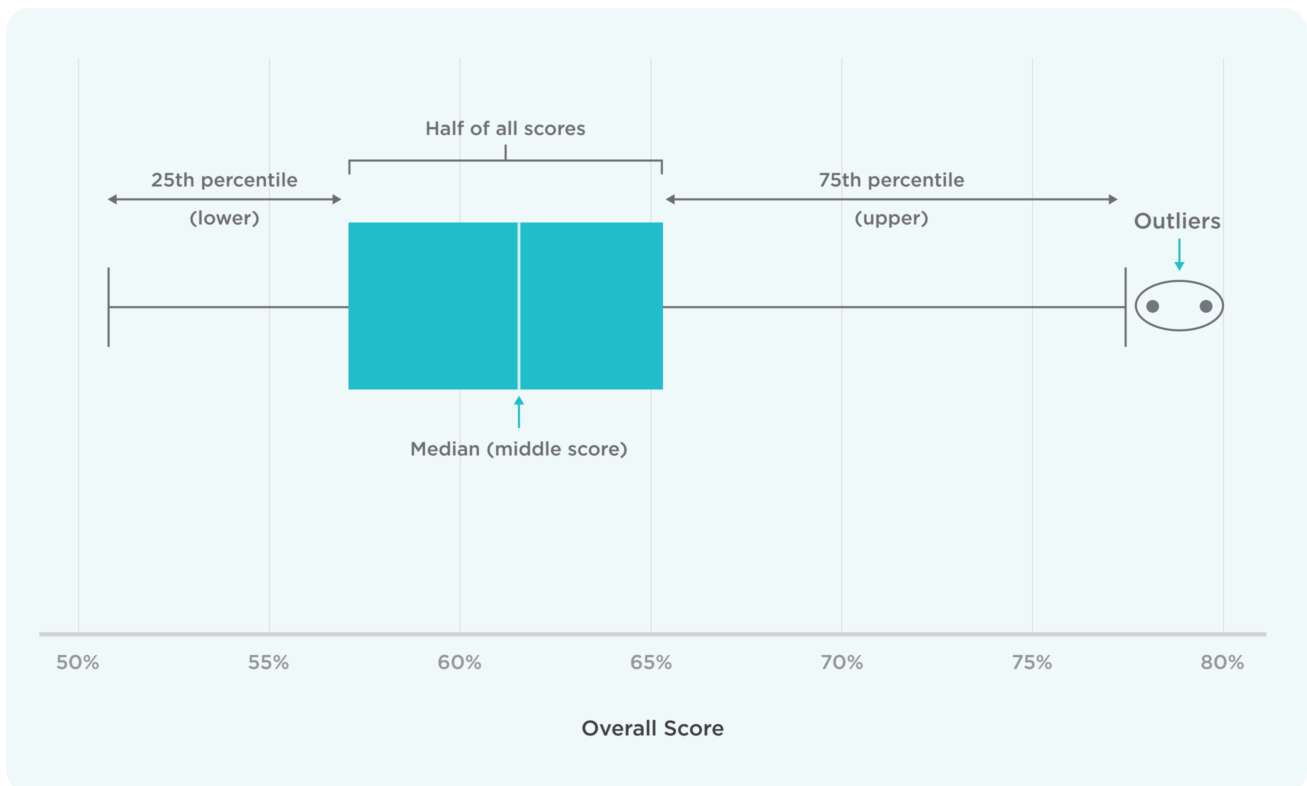
Your response has been recorded.

Appendix 6: Interpreting Boxplots

A Boxplot graphically displays results and can be interpreted as follows:

- The coloured box represents the boundaries between the 25th percentile (lower) and the 75th percentile (upper) therefore the box embraces the middle half of all the scores
- The median (middle score or 50th percentile) is indicated by the thick white line within the box – note that this may differ from the mean (average) score)
- The lines extending either side of the box represent the range of scores (excluding the outliers or extreme values)
- Outliers are values outside the general range of scores and are shown as:
    - o Circles – mild outliers (1.5 x interquartile range or 1.5 box-lengths from the edge of the box)
    - o Stars – extreme outlines (3.0 x interquartile range or 3.0 box lengths from the edge of the box)

Figure 4: Overall Scores: Summary from SAFE Sites



Appendix 7: SAFE Site Survey Results

SAFE Site Survey: experience of implementing the SAFE Tool

Please rate the extent to which you think each of the following statement applies			
	Disagree*	Not Sure	Agree#
a) The SAFE Audit Tool was comprehensive	0	0	12
b The SAFE Audit Tool was easy to navigate	0	2	10
c) The SAFE Audit Tool 'Items' and corresponding 'Measurement notes' were clear	2	2	8
d) SAFE Research Team communication was accessible and timely	0	0	12

Note: *created by combining 'Strongly disagree' and 'Disagree'; #Created by combining 'Agree' and 'Strongly Agree'

On a scale of 1 ('Not at all useful') to 5 ('Very useful')	1	2	3	4	5
How useful was, or would have been, the clinical files audit component of the SAFE Audit Tool?	0	0	2	4	6

Appendix 8: Outline of amendments to the SAFE Tool

Recommendation concerning broad overall changes to the SAFE Tool include:

- simplification and splitting of some of the complex *Items* with multifaceted *Measurement notes*
- greater clarification concerning *Items* that relied on clinical files audits
- removal/replacement of *Items* that are not uniformly applicable across sites
- rewording to ensure relevance of the Tool for future use.

Specific comments pertaining to each domain are outlined below.

Amendments to SAFE Tool

Domain 1: Identification and Response

- Greater clarity concerning the clinical files audits
- Consider perpetrators in all items and measurement notes
- Ensure consistency with MARAM Framework

Domain 2: Staff Education and Training

- Review items shaped by the MARAM Framework
- Consider including items that cover staff training separate from mandated training

Domain 3: Staff Support

- Include items covering Family Violence Contact offers separate, and in addition to, Family Violence Clinical Champions

Domain 4: Organisational Policies, Procedures and Guidelines

- No significant issues – general review of items to maximise clarity

Domain 5: Governance and Leadership

- Review of items and measurement notes to ensure they are clear and universally relevant to all health services

Domain 6: Intersectionality and Diversity

- Ensure items concerning Aboriginal and Torres Strait Islander peoples are distinct from those referring to diverse communities
- Include item re use of bilingual workers

Domain 7: Collaboration and Service Integration

- Clarify wording on some items – e.g., review use of ‘collaboration’, ‘referral pathways’ and/or ‘service integration’ in Tool
- Revise/remove item concerning memorandum of understanding and/or agreement with relevant services for family violence referrals and case management

Domain 8: Infrastructure – Physical Environment and Financial Resources

- Revise items concerning publicly visible posters and brochures (especially given restrictions in new facilities)

Domain 9: Organisational Culture

- Consider the potential to revise/replace some items to make the domain more aspirational and in line with the *Gender Equality Act 2020*
- Reconsider/replace items that rely on the People Matters Survey results
- Revise wording of item referring to equal remuneration of staff at all levels of organisation – consider replacing

Domain 10: Quality improvement and Evaluation

- Review of items and measurement notes to ensure they are clear and relevant to all health services.

Consideration should also be given to the following:

- creation of a reduced version of the SAFE Tool suitable for use in supported health services
- assist sites to develop the necessary skills to undertake clinical file audits.

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Thank you

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The Royal Women’s Hospital and the University of Melbourne acknowledges and pay respect to the peoples of the Kulin Nations, the Traditional Custodians of the Country on which our sites at Parkville and Sandringham stand and we pay our respects to their Elders past, present and emerging.