IN THE MATTER OF THE ROYAL COMMISSION INTO FAMILY VIOLENCE

STATEMENT OF FRANCES MARIE DIVER

[redacted]

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Filed on behalf of: State of Victoria
Prepared by:
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I, FRANCES MARIE DIVER, Deputy Secretary, Health Service Performance and Programs Division, Department of Health and Human Services, SAY AS FOLLOWS:

1. I am the Deputy Secretary of the Health Service Performance and Programs Division in the Department of Health and Human Services (**Department**). I have held this position since December 2010.

2. I am also a member of a number of committees, including the Hospital Principal Committee (one of four Australian Health Ministers' Advisory Committees), the Capital Projects Board (a whole of government health capital governance group), the Jurisdictional Advisory Committee for the Australian Independent Hospital Pricing Authority, and the Victorian Comprehensive Cancer Centre Steering Committee (of which I am chair).

3. I have held various positions in the Department since 2004. Before commencing work with the Department in 2004, I had worked as, among other things, the manager of Patient Access Strategy at Bayside Health, a site manager at Monash Medical Centre, Southern Health, an information manager at the BreastScreen Victoria Coordination Unit, a midwife and a registered nurse. A copy of my curriculum vitae is attached to this statement at **Confidential Attachment FD-1**.

4. I have a Masters of Business Administration from the University of Melbourne and a Bachelor of Applied Science (Advanced Nursing) from La Trobe University.

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SCOPE OF STATEMENT

5. I have received a notice from the Royal Commission into Family Violence pursuant to s 17(1)(d) of the *Inquiries Act 2014* (Vic.) requiring me to attend to give evidence at the Royal Commission and to provide a written witness statement.

6. In this statement, I respond to a request by the Royal Commission for information regarding Module 18 (The role of the health system).

7. I understand the Royal Commission is particularly interested in understanding what role health services, and particularly those services for which the Department has responsibility, can and do play in preventing, intervening in and responding to family violence.

THE HEALTH SERVICE PERFORMANCE AND PROGRAMS DIVISION

8. The Health Service Performance and Programs Division (**Division**) is the primary interface between the Victorian Government and the hospital and health service sector. The Division is relevantly responsible for:

   8.1 health service funding, programs and policy;

   8.2 governance and formal accountability arrangements, including supporting the development of high performing health services; and

   8.3 system-wide planning and management.

9. The Division plays a critical role in capital projects and service planning and oversees certain specialist clinical program areas including drugs, blood products and new technology. The Division also has responsibility for ambulance services and regulatory responsibility for private hospitals.

10. As it is presently configured, the Division was established on 14 April 2014. It consists of six branches and more than 170 full-time equivalent staff. In 2014-2015, the Division was directly accountable for a service delivery budget of approximately $11.3 billion.

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11. The Division is focused on:

    11.1 improving the quality, effectiveness and efficiency of all hospital and ambulance services in both metropolitan and rural areas; and

    11.2 increasing the sustainability of the Victorian health system.

12. The Division also provides sector-wide leadership in the following areas:

    12.1 accountability of public service agencies;

    12.2 governance, including clinical governance, and regulation of the public and private sector;

    12.3 health service planning and development;

    12.4 consumer and carer participation and experience;

    12.5 capital asset investment and management;

    12.6 policy and program development;

    12.7 facilitation of technological and biomedical research and innovation.

AN OVERVIEW OF VICTORIA'S HEALTH SYSTEM

System structure

13. The Victorian health system is comprised of a diverse range of public and private service providers.

14. Public hospital funding comprises the largest component of the State's health budget, and provides for a significant proportion of the hospital services delivered to Victorians. Some public hospitals and private hospitals provide 24-hour emergency care. A range of ambulatory care services are also provided, either co-located with hospitals or located in community-based facilities.

15. There are currently 81 private hospitals and 87 private day procedure centres registered in Victoria. Private hospitals and day procedure centres provide a wide range of services from inpatient and same day medical and surgical care, to specialist services that include emergency medicine, intensive care,

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cardiac, obstetrics and neonatal care, oncology, renal dialysis, mental health services and rehabilitation.

16. The State is the majority funder of public health services. In Victoria, there are currently 90 individual public health service entities which comprise 'public health services', 'public hospitals', 'denominational hospitals', Ambulance Victoria, the Victorian Institute of Forensic Mental Health (**Forensicare**), a privately-operated hospital and 'multi purpose services'. Ambulance Victoria is a public health service which is funded by the Victorian Government and third parties to provide emergency care and transport and retrieval services on a statewide basis.

17. The public sector mental health service system in Victoria comprises clinical and non-clinical services. Public clinical mental health services in Victoria are provided by a network of 18 designated (under the *Mental Health Act 2014* (Vic.)) public health service providers. Under the auspices of these 18 public health service providers, there are 21 area mental health services for adults, 17 aged persons' mental health services and 13 child and adolescent mental health services. They provide a mix of hospital and community based services across the continuum of care. Non-clinical mental health services are provided by Mental Health Community Support Services (**MHCSS**) which are publicly funded and delivered through the non-government sector. MHCSS focus on addressing the impact of mental illness on a person's life and work within a recovery and empowerment model to maximize people's opportunities to live successfully in the community. In addition, Forensicare provides inpatient and community services to mentally ill offenders and forensic mental health patients.

18. Community health services provide a major platform for the delivery of a range of state-funded, population-focussed and community-based health and human services to meet local community needs. Services offered may include nursing and allied health services, drug and alcohol services, disability services, dental services, post-acute care services, home and community care services, and mental health services. In Victoria, there is a network of 88 community health services. These community health services also deliver services funded by the Department of Education and Training and the

Department of Justice and Regulation such as, for example, early childhood intervention services and problem gambling services.

Commonwealth and State government roles

19. The Commonwealth and State governments enter into agreements for financing, accountability and reform of health services. The last round of Council of Australian Governments (**COAG**) national health reform agreements (in 2011) provided for the establishment of two key new bodies: the National Health Performance Authority (**NHPA**) and the Independent Hospital Pricing Authority (**IHPA**). Under these arrangements, the scope of public health service performance monitoring by the Commonwealth has been extended (to an entity basis and not just at a statewide aggregate level). The Commonwealth's funding share for public hospitals is now directed through the IHPA pricing policy.

20. In the 2014-15 Commonwealth Budget, it was announced that the Commonwealth would move to a new funding approach from 2017, indexed by population growth and the Consumer Price Index. Furthermore, the Commonwealth has established a process to examine the roles and responsibilities of the Commonwealth and the States through the Federation White Paper and related Tax Reform White Paper processes.

21. At present, the States are recognised as system managers of the public hospital system. The Commonwealth is described as the system manager of the primary health care system, and from 2015-16 this includes the aged care system nationally.

22. The Commonwealth funds universal benefits schemes for privately operated medical services (via the Medicare Benefits Schedule) and pharmaceuticals (via the Pharmaceutical Benefits Scheme). The Commonwealth is the majority funder of primary health care, particularly primary care services delivered by or through general practices.

23. State and local Governments also fund a range of programs focused on prevention and improving access to primary health care services for vulnerable groups through, for example, Aboriginal Community Controlled Health Organisations and Community Health Centres. This funding includes

the State's investment in 28 Primary Care Partnerships to improve access to services and continuity of care. Each Primary Care Partnership is intended to improve service coordination, chronic disease prevention, integrated health promotion, and partnership development. A Primary Care Partnership is made up of a range of member agencies, including hospitals (and their area based mental health services), community health organisations and local government as core members. Primary Health Networks currently being established by the Commonwealth are expected to participate in Primary Care Partnerships. Other organisations, such as drug treatment services and disability services, are also members of each Primary Care Partnership. The partners can also be specific to local issues and needs. For example, some Primary Care Partnerships have engaged with the police, schools and community groups.

24. The Commonwealth Government is responsible for Primary Health Networks, which replaced Medicare Locals from 1 July 2015. In Victoria there are six Primary Health Networks, being North Western Melbourne, Eastern Melbourne, South Eastern Melbourne, Grampians and Barwon South West, Murray and Gippsland.

25. The Commonwealth is also the majority funder of residential aged care services which are provided mostly by private providers. The Commonwealth also assumed national responsibility for both residential and non-residential aged care services from 1 July 2015.

26. Private hospitals and privately practising specialists are mostly funded through private health insurance and the Medicare Benefits Scheme (which is subsidised and regulated by the Commonwealth), and private contributions (or co-payments). Some private hospitals provide clinical mental health services, which are primarily inpatient-based.

VICTORIA'S HEALTH GOVERNANCE FRAMEWORK

Introduction

27. Victoria has a long-established system of devolved governance for public healthcare delivery.

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28. The *Health Services Act 1988* (Vic.) (**Act**) provides for different entities that provide publicly funded health services including 'public health services', 'denominational hospitals', 'public hospitals', and 'multi purpose services' and a 'privately operated hospital'. Ambulance Victoria is established separately under the *Ambulance Services Act 1986* (Vic.).

29. Victoria's public health service entities (including Ambulance Victoria) are governed by boards of directors, the members of which are appointed by the Governor-in-Council on the recommendation of the Minister for Health (see, for example, ss 33, 65T and 115E of the Act).

30. These entities are incorporated public statutory bodies established under the Act (see ss 31, 65P and 115A) and, in the case of Ambulance Victoria, the *Ambulance Services Act 1986* (Vic.) (see s 23). Victorian public health service entities have separate legal status and are not part of the Crown (see, for example, ss 31A, 65Q and 115B of the Act).

31. With the exception of Forensicare, the governance of public clinical mental health services sits with the responsible public health service board. Forensicare has an independent board and is subject to a separate funding and service agreement with the Department.

32. The governance arrangements for community health services fall into two categories. Community health services that are integrated within public health services are subject to the governance arrangements that apply to these public entities. Standalone community health centres (**CHCs**) are registered under the Act (see, for example, s 47) and are governed by independent boards. CHCs are subject to an annual self-evaluation process to ensure compliance against gazetted performance standards and ongoing monitoring arrangements by the Department. Some of these community health centres operate as standalone organisations with their own management structures while others are integrated within public health services.

33. Similarly, some Centres Against Sexual Assault (**CASAs**) are run within public health services and others have independent boards. However, all of these organisations receive State funding and are subject to ongoing monitoring arrangements by the Department.

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34. Thirteen metropolitan health services and six major regional health services are defined under the Act as 'public health services' (see Schedule 5). There are also three denominational hospitals delivering public health services in Victoria (see Schedule 2 to the Act). Nine of the subregional health services, eleven local health services and 36 small rural health services are defined in the Act as 'public hospitals' and are governed by boards (see Schedule 1 to the Act). Among the small rural health services, seven are multi purpose services (see, for example, s 115V (2) of the Act). Multi purpose services are integrated health and aged care services that provide flexible service options for small rural and remote communities. They are subject to governance provisions similar to those applying to public hospitals and are governed by boards.

35. In January 2012, the Department issued the *Victorian Health Services Governance Handbook – A Resource for Victorian Health Services and Their Boards* (**Attachment FD-2**). This document provided a description of the governance and funding arrangements for health services in Victoria. It was intended, among other things, to assist public health service entities and their boards better understand their roles.

36. The status of public health service entities is best described as semi-autonomous. The State is responsible for system policy, funding and strategic priorities. Individual public health service entities, through their boards and chief executive officers, are responsible for making operational decisions within these parameters. Figure 1 below describes the public health service governance arrangements in Victoria.

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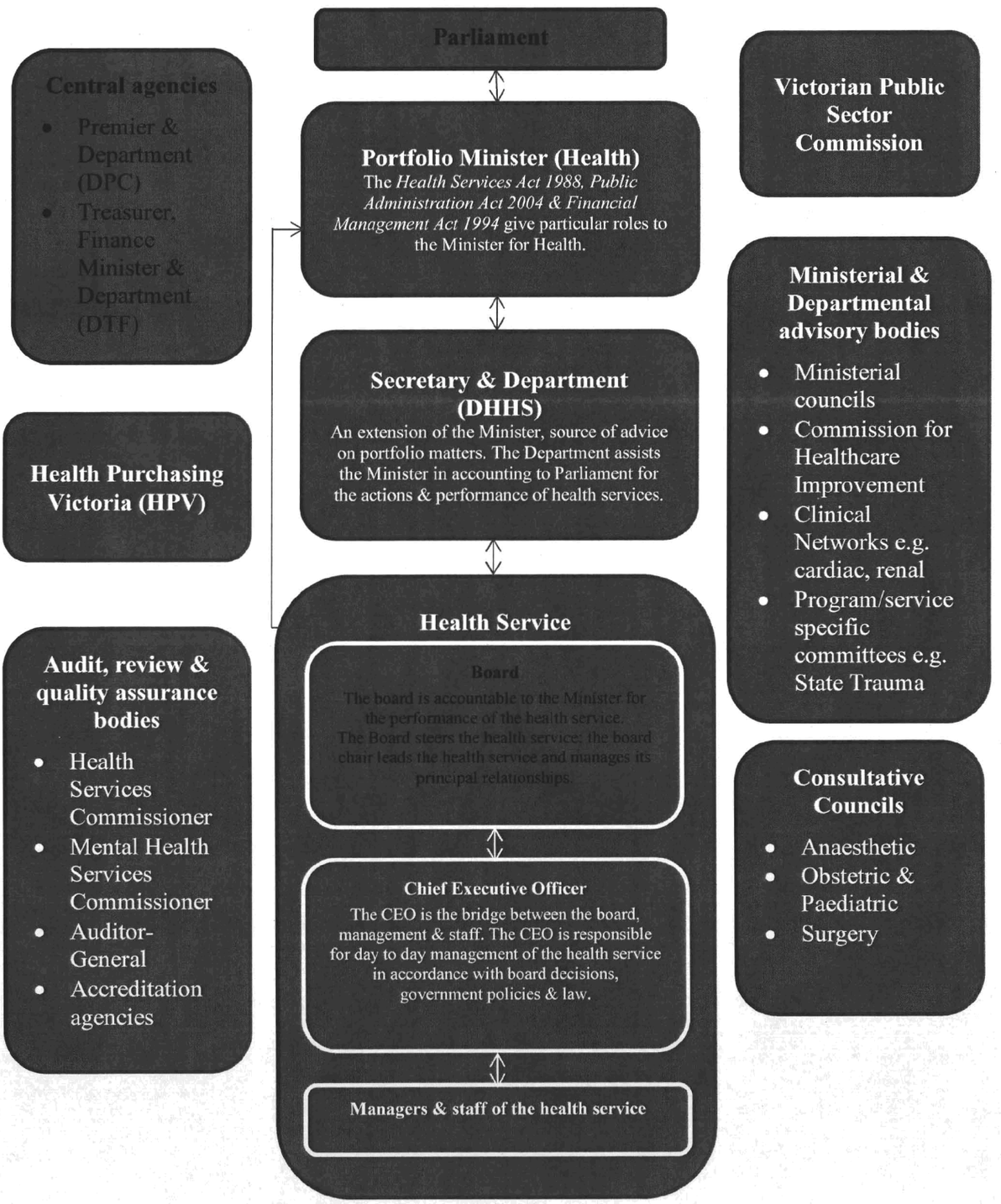
Figure 1: Victorian public health service governance



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37. The operational independence of health services is subject to various accountability measures. A regulatory and performance management framework applies to health service entities to make them accountable to the State Government and others. Some of the key features of this framework are as follows.

Strategic priorities set by the State Government

38. The State Government sets strategic priorities through policy and budgetary measures. Public health service entities make local decisions within these parameters. Among other things, the board of each public health service is required, by s 65ZF of the Act, to have a strategic plan approved by the Minister which is consistent with the strategic priorities set by the State Government and takes account of the needs of the local catchment population.

Statements of Priorities and annual funding guidelines

39. The key service delivery and accountability measure for each health service entity is an annual Statement of Priorities (see, for example, ss 65ZFA and 65ZFB of the Act). A Statement of Priorities is, in effect, an agreement between a health service entity and the State Government about, among other things, the services to be provided by that entity and the way in which those services are to be provided. The Statement of Priorities must be consistent with the strategic plan of the health service entity. It is also aligned to government policy directions and priorities. Among other things, it sets out, for the relevant health service in the applicable year, a statement of priorities, the key performance targets and benchmarks, and the allocation of funding. The priorities include 'strategic priorities' and 'performance priorities'.

40. For major public health services, Ambulance Victoria and Dental Health Services Victoria, Statements of Priorities are agreed annually between the Minister for Health and the board of the relevant public entity. For sub-regional and local health services and small rural health services, Statements of Priorities are agreed annually between the Secretary to the Department and the board. For Forensicare, the Statement of Priorities is agreed annually between the Minister for Mental Health and the board.

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41. Statements of Priorities are made publicly available. By way of example, a copy of the *2014-15 Statement of Priorities* between the Minister for Health and Austin Health is attached at **Attachment FD-3**. As illustrated at pages 6 to 8 of this document, each Statement of Priorities sets out, among other things: a number of 'strategic priorities'; the 'action' to be taken in respect of each of those priorities; and the 'deliverable' which is to be achieved as a result of that action. It also sets out key performance indicators for various 'performance priorities' relating to safety and quality, financial sustainability and access.

42. In entering into a Statement of Priorities, a public health service entity agrees to comply with all applicable policies and guidelines issued by the Department. For example, the Department issued in 2013 the *Victorian Clinical Governance Policy Framework* (**Attachment FD-4**) which applies to State-funded health services.

43. The entity also agrees to comply with all applicable requirements, policies, terms or conditions of funding specified or referred to in the annual *Victorian Health Policy and Funding Guidelines* issued by the Department. These guidelines act as system-wide terms and conditions of funding for State-funded health service entities. The guidelines include information about government initiatives and program-specific accountabilities. The 2014-15 guidelines (**Attachment FD-5**) included matters relating to, among other things, identifying, intervening early in and responding to family violence (see pages 1, 14 and 227). Each 2014-15 Statement of Priorities highlights the Victorian Government's general commitment to providing responsive, integrated and innovative health care options. One specific commitment relates to supporting emergency departments to better identify, respond and intervene early in instances of family violence and sexual assault.

44. Each 2015-16 Statement of Priorities includes a mandatory action that requires health services to develop deliverables for how they will strengthen their response to family violence. A copy of the 2015-16 interim Statement of Priorities guidelines has been released to health services and all health services are currently developing their Statement of Priorities in consultation with their boards for submission to the Department by September this year. Finalised Statements of Priorities are expected to be made public in

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November this year. A copy of the interim guidelines is attached at **Confidential Attachment FD-6**.

The Performance Monitoring Framework

45. The *Victorian Health Service Performance Monitoring Framework 2014-15* (**Attachment FD-7**) sets out principles relating to the Department's monitoring, analysis and evaluation of a health service's performance and, in particular, its performance measured against the requirements of its Statement of Priorities. The 2015-16 framework is not yet finalised but is similar to the previous year's. A copy of the interim framework for 2015-16 is attached at **Confidential Attachment FD-8**.

46. The framework provides for a formal monitoring and meeting cycle and specifies indicators that are formally monitored. The level of monitoring and intervention is based on principles of responsive regulation (that is, accountability through agreed mechanisms or through interventionist methods if those mechanisms fall short). The framework sets out a performance assessment system involving three levels of monitoring:

    46.1 **Standard monitoring**, which applies to health services with no significant performance concerns, is the least intrusive level of monitoring, with meetings occurring on a regular (usually quarterly) basis between the Department and the health service to discuss performance;

    46.2 **Performance watch**, which applies to health services with emerging performance deterioration, involves intensified monitoring and increased regularity of performance meetings between the Department and the health service, and meetings may include the chair of the service's board; and

    46.3 **Intensive monitoring**, which applies to health services with significant and continuous under-performance, involves a more intensive scope and frequency of monitoring, requiring involvement of the board chair, provision of detailed performance analysis and risk mitigation strategies at meetings.

47. In respect of serious performance problems affecting a public health service entity, the Minister for Health and the Secretary of the Department also have various powers under the Act. For instance, the Minister has the power to recommend to the Governor in Council that one or more members of a public health service entity's board be removed (see, for example, ss 35 and 65V) and replaced. The Minister may also appoint up to two delegates to the board (see, for example, ss 40C and 65ZAA). In some circumstances, the Minister may, if necessary, intervene in the management of the public health service entity and appoint an administrator (see, for example, s 69F). Similar provisions exist for Ambulance Victoria in the *Ambulance Services Act 1986* (Vic.) (see ss 17, 22B and 35).

48. In addition to reporting to the Department pursuant to the Performance Monitoring Framework, each public health service entity must prepare an annual report and provide it to the Victorian Parliament. The report relates to the service's operation and contains financial statements. Annual reports are publicly available.

Independent review and audit bodies

49. In addition to scrutiny of a public health service entity by the Department, there are, in relation to the State's health system, a number of independent review or audit bodies, including:

    49.1 the Health Services Commissioner;

    49.2 the Mental Health Complaints Commissioner;

    49.3 the Victorian Ombudsman;

    49.4 the Coroners Court of Victoria;

    49.5 the Victorian Auditor-General; and

    49.6 the Independent Broad-based Anti-corruption Commissioner.

Accreditation of public health services

50. Each Statement of Priorities contains a number of 'performance priorities' which the public health service entity is expected to address. Those

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performance priorities include priorities relating to 'safety and quality performance'. One of those priorities requires that the entity achieve 'full compliance' with health service accreditation.

51. The State Government requires that Victorian public health services be accredited. Accreditation is part of the regulatory framework relating to service delivery by public health service entities. A public health service is accredited when it is externally assessed as meeting the relevant set of standards.

52. Accreditation of Victorian public health services occurs pursuant to the Australian Health Service Safety and Quality Accreditation Scheme. The Scheme was established by the Australian Commission on Safety and Quality in Health Care. In 2006, COAG established the Commission to lead and coordinate national improvements in the safety and quality of health care. To this end, the Commission issued the *National Safety and Quality Health Service Standards*. Under the Scheme, public health services are required to be accredited against the Standards. The Standards consist of 10 standards and 256 actions in respect of those standards. A copy of the Standards is attached to this statement at **Attachment FD-9.**

53. The accreditation process is mandatory. An independent and external accrediting agency assesses the quality and safety of care provided by a health service. The agency must be approved by the Commission. The agency measures the health service's performance against the standards and the related actions in the Standards.

54. There are three possible accreditation outcomes:

    54.1 accreditation is awarded;

    54.2 some actions in the Standards are not met and rectification is required;

    54.3 accreditation is not awarded.

55. If some of the 256 actions are not met by a health service, the health service will have some time to address those actions and, at the end of that time, the accrediting agency will make a final determination about accreditation. The

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accrediting agency must also consider whether or not any significant risks to patient safety have been identified.

56. The Department is responsible for verifying the accreditation status of Victorian public health service entities and taking any necessary action to ensure patient safety in the event of an entity's failure to attain accreditation or in the event of identification of significant risks to patient safety. In this regard, a copy of the then Department of Health's document entitled *Accreditation Regulatory Role – A Guide for Department of Health Staff* (together with its appendices) is attached to this statement at **Attachment FD-10**.

57. The Standards focus on areas that are essential to improving safety and quality of care for consumers of health services. The Standards do not specifically refer to family violence. Action item 1.8, which is entitled *Adopting processes to support the early identification, early intervention and appropriate management of patients at increased risk of harm*, does, however, provide for the inclusion of systems that identify patients at increased risk of harm and the taking of early action to reduce risks for such patients.

58. The Standards also apply to public clinical mental health services (under public health services) and public dental health services (in community health).

59. The Standards are currently being reviewed and the updated standards are expected to be released for consultation in a month. The next version of the Standards will be complete in 2017-18.

60. In addition, publicly-funded mental health services are required to comply with the National Standards for Mental Health Services.

61. The Department requires community health services in receipt of State funds to be accredited either under the Quality Improvement Council's Quality Innovation Performance Standards or the EQuIP standards issued by the Australian Council on Healthcare Standards. These standards do not refer expressly to family violence.

62. In relation to aged care, the Commonwealth's Australian Aged Care Quality Agency is responsible for accrediting residential aged care services against the Accreditation Standards set out in the *Quality of Care Principles 2014*

(Cth). In Victoria, the national Community Care Common Standards (**CCCS**) apply to the State and Commonwealth funded Home and Community Care Program. For Victorian Home and Community Care services, monitoring of compliance against the CCCS is undertaken by third party contractors commissioned by the Department on a periodic basis. For other Commonwealth-funded and managed community aged care programs, monitoring of compliance against the Commonwealth Home Care Standards is undertaken by the Australian Aged Care Quality Agency.

Regulation of private hospitals

63. The Department regulates private hospitals in Victoria under Part 4 of the Act and the *Health Services (Private Hospitals and Day Procedure Centres) Regulations 2013* (Vic.) (**Regulations**). The objectives of the Regulations are to provide for the safety and quality of care of patients receiving health services in private hospitals and day procedure centres.

64. The Department has a role in ensuring compliance against the Act and the Regulations. This is achieved through a risk-based regulatory approach and includes site inspections when identified as required.

65. In addition, from time to time the Department receives complaints from patients, staff and members of the public in relation to registered private facilities. The Department follows up complaints with the health service and they are all responded to. If the complaint alleges a matter that may present a serious and immediate health risk to patients and is an alleged breach of the Act or the Regulations, the Private Hospitals Branch of the Health Service Performance and Programs Division of the Department may conduct an on-site inspection.

66. Private hospitals and day procedure centres are required through a condition on registration and through contracts with private health insurers to be accredited against the National Safety and Quality Health Service Standards.

67. The Department also informs the sector of the Department's policies and best practice that they may consider for their health services. In addition, the Department's consultation with peak bodies regarding policies and best practice can facilitate their adoption within the private sector.

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68. Options available to the Department where issues of compliance have been identified can include, for example:

68.1 providing recommendations and requiring an action plan from the facility to address the issues raised;

68.2 increasing frequency of inspections;

68.3 placing conditions to the Registration of the facility;

68.4 refusing to renew a registration;

68.5 prosecution for a breach of the Act or Regulations;

68.6 a recommendation to the Minister that the Registration be revoked.

Accreditation of health practitioners

69. The National Registration and Accreditation Scheme (**NRAS**) for health practitioners commenced in 2010. It applies to over 600,000 health professionals across Australia. Professionals currently regulated under the NRAS are:

69.1 chiropractors;

69.2 dental practitioners;

69.3 medical practitioners;

69.4 nurses and midwives;

69.5 optometrists;

69.6 osteopaths;

69.7 pharmacists;

69.8 physiotherapists;

69.9 occupational therapists;

69.10 podiatrists;

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69.11 psychologists;

69.12 Aboriginal and Torres Strait Islander health practitioners;

69.13 Chinese medicine practitioners; and

69.14 medical radiation practitioners.

70. Each profession has a National Board which regulates the profession, registers practitioners and develops standards, codes and guidelines for the profession. The Australian Health Practitioner Regulation Agency (**AHPRA**) administers NRAS and provides administrative support to the National Boards.

71. Each National Board is responsible for, among other things, approval of accredited programs of study to provide qualifications for registration in the relevant health profession. These registration standards are available on the website of each National Board. A list of the National Boards and their websites is attached to this statement at **Attachment FD-11**. In order to maintain their registration, practitioners are required to undertake a required amount of Continuing Professional Development (**CPD**) each year.

72. All National Boards have issued codes of conduct for health practitioners, with most adopting a common code of conduct (**Attachment FD-12**). Section 3.6 of the common code relates to children and young people and reinforces the mandatory obligations of practitioners to report child abuse and neglect, and the responsibility of practitioners to be aware of the applicable obligations. It sets out matters relevant to good practice.

73. Unregistered health care workers are those practitioners who do not require statutory registration in order to provide health services. These self-regulating professions may accredit or otherwise assess and recognise qualifying programs for membership to the professional association. Examples of professional associations with such an accreditation process include the Australian Association of Social Workers and the Dieticians Association of Australia. These professional associations may run CPD and other events on topics of interest to members. In April 2015, the COAG Health Council agreed to the terms of the first National Code of Conduct for unregistered health care workers. State governments are now examining the implementation of this national code.

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74. In addition, clinical guidelines, policy and training programs are usually developed by professional associations or organisations with expertise in the areas of practice for which they have responsibility. In order to inform these clinical guidelines, policies and training programs, professional associations or organisations may draw on a range of government policies, standards and frameworks. Some of the resources developed by specialist medical colleges and which refer to family violence are described in **Confidential Attachment FD-13** to this statement.

75. In Victoria, the Department also funds clinical networks to bring together health professionals, patients, consumers, carers and stakeholder organisations to work on a collaborative basis and provide leadership for clinical service development across the full spectrum of healthcare. The activities of each network may involve developing, disseminating and supporting implementation of best practice clinical guidelines and patient care pathways at a system level. There are seven clinical networks relating to the following areas: cancer, cardiac, emergency care, maternity and newborn, palliative care, paediatric, renal and stroke. The Department is currently establishing an eighth network for critical care.

FAMILY VIOLENCE: PREVENTION, EARLY INTERVENTION AND RESPONSES

76. Victoria's health system provides a universal platform for promoting the health and wellbeing of all Victorians. The health system has an important role in the prevention of, early intervention in and responses to family violence.

Primary prevention

77. The Department provides funding to VicHealth to promote and facilitate, among other things, primary prevention of violence against women. In 2007, VicHealth published *Preventing Violence Before It Occurs: A Framework and Background Paper to Guide The Primary Prevention of Violence Against Women in Victoria* (**Attachment FD-14**). In accordance with this framework, VicHealth has developed or funded a number of resources relevant to prevention of family violence (see https://www.vichealth.vic.gov.au/programs-and-projects?q=&category=preventing%20violence%20against%20women). VicHealth is currently working in partnership with Our Watch and Australia's National Research Organisation for Women's Safety (**ANROWS**) to develop

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the National Primary Prevention Framework, due for release in November 2015.

78. One example of the resources funded by VicHealth is the *Generating Equality and Respect Program*, a primary prevention, site-based approach delivered in Melbourne's South East. The Program commenced in 2012 and will run for 3½ years with over $1 million in VicHealth funding. Activities are delivered in various settings in the following ways:

78.1 Baby Makes 3 first time parent program is being delivered through Maternal Child Health Services;

78.2 MonashLink Community Health Service and Monash City Council are undergoing organisational culture change to promote respect and gender equality within the workplace, and then extending this culture into the broader community through the programs and services they deliver;

78.3 a localised Monash Partners in Prevention Network is actively supporting youth practitioners to deliver respectful relationships education and promote equality through their programs and services – members of the Network include local teachers, police, school nurses, youth services and community organisations; and

78.4 engagement and partnership development activity has occurred within local workplaces including workplaces in male-dominated industries – such a project commenced with Bosch in 2013.

79. Other examples include:

79.1 Respect Responsibility and Equality Program guides – a set of 5 implementation guides for prevention activity in multiple settings such as: maternal and child health, workplaces, youth/education, Christian faith settings and local government. These guides were produced by organisations in community health, women's health, local government and community sectors (see https://www.vichealth.vic.gov.au/search/guide-to-equality).

79.2 Equal Footing workplace toolkit – funded by the Victorian Government, the Equal Footing program involved VicHealth engaging with workplaces in

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finance, hospitality, retail, engineering, human resources and not-for-profit sectors to build the toolkit, which promotes gender equality and respectful relationships in the workplace (see https://www.vichealth.vic.gov.au/search/equal-footing-toolkit).

79.3 the Y Respect Gender Project at YMCA Victoria – funded in part by VicHealth to promote gender equity in the YMCA workforce and among its volunteers.

80. VicHealth has also established *Preventing Violence Against Women* short courses which provide practical knowledge and skills on effective approaches courses for individuals and organisations. Short courses are available for project and program level staff (a two-day course) and workplace executives (a three-hour workshop), with additional training for cross-sector organisations to promote bystander action in the workplace (a three-hour session) (see https://www.vichealth.vic.gov.au/courses-and-events/vichealth-short-courses).

81. VicHealth has also produced evaluation resources to help practitioners evaluate their work and help program and policy managers consider how to evaluate the primary prevention of violence against women.

Early intervention and responses

82. Health professionals are uniquely placed, often as a first responder, to identify individuals affected by family violence, provide necessary treatment and care, and make safe, timely and effective referrals to relevant services and supports.

83. Under Victoria's governance framework for health services, the Department provides system, policy and program guidance and health services must then ensure that:

83.1 this guidance is reflected in local policies, procedures and protocols; and

83.2 staff are suitably informed about these requirements and skilled and supported to adhere to them.

84. This governance framework has included a strong emphasis on improving service coordination to ensure individuals have access to services they need,

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as well as early intervention and coordinated care. For example, in relation to family violence the Department's *Family Violence Risk Assessment and Risk Management Framework and Practice Guides (CRAF)* (2nd ed., 2012) (**Attachment FD-15**) provides a framework for the identification of family violence and guidance on risk assessment and management. The Department has developed a series of CRAF practice guides that are suitable for use by a range of professionals including those working in the health sector.

85. The Department also funds health services, registered training providers and other organisations to develop, deliver and evaluate professional development initiatives aimed at promoting best practice. The Department does not, however, directly deliver or mandate professional development initiatives for the health workforce. I now refer to some examples of initiatives funded by the Department. In particular, the Department has commissioned the development and delivery of training for the health workforce in relation to, among other things, the *Strengthening Hospital Responses to Family Violence* initiative.

Strengthening Hospital Responses to Family Violence initiative

86. The *Strengthening Hospital Responses to Family Violence* initiative was designed to optimise the relationship between health services and the family violence system. The project is aligned with the CRAF. The project is overseen by an Advisory Committee, chaired by the Department, with representatives from health services and family violence services. A copy of the project brief is attached to this statement at **Confidential Attachment FD-16**.

87. This initiative aligns with the *National Plan to Reduce Violence Against Women and their Children 2010-2022*, which recognised health professionals as an early contact for victims/survivors.

88. The objectives of this initiative, as outlined in the project brief, are to:

88.1 apply a framework of sensitive practice to increase the competence of key staff within the hospital environment to better identify and respond to violence against women;

[redacted]

88.2 enhance the application of tested program design and approaches across hospital sites;

88.3 strengthen relationships between hospitals and the integrated family violence system; and

88.4 build capacity of key staff to plan and implement primary prevention initiatives.

89. The project is designed to be consistent with the CRAF. It also supports the development of relationships between hospitals and family violence services, particularly for referral and consultation by family violence services.

90. The initiative is overseen by a project Advisory Committee, chaired by the Department, with representatives from the Office of Women's Affairs, the Royal Women's Hospital, Bendigo Health, Our Watch and Domestic Violence Victoria.

91. The Victorian Government has contracted Our Watch, previously known as the Foundation to Prevent Violence against Women and their Children, to manage the pilot project. Our Watch is a company limited by guarantee with an independent board of directors. Our Watch has partnered with the Commonwealth Government, the Victorian Government, the South Australian Government and the Northern Territory Government.

92. The pilot sites are the Royal Women's Hospital (emergency department) and Bendigo Health (emergency department, maternity and mental health units).

93. An evaluation of the initial pilot stage is being conducted by Our Watch, and the project products are being finalised in a project kit for review.

94. Up to 2014-15, the Victorian Government had invested $550,000 in the Strengthening Hospital Responses to Family Violence project with the aim of developing a sustainable, transferable model for other Victorian hospitals. This funding has come from two sources: $300,000 from the Office for Women and $250,000 from the Department of Health and Human Services.

95. The Department used this funding to extend the Strengthening Hospital Responses to Family Violence initiative, by commissioning the Royal Women's Hospital (in partnership with Bendigo Health) to develop a broader

project kit, and augment the work to date. In 2014-15, funding was invested to:

95.1 expand data management systems and processes to enable consistent, efficient data capture, retrieval and reporting on family violence disclosure and responses;

95.2 embed new hospital family violence protocols in practice, including developing staff training packages that are appropriately tailored to frontline clinicians and staff in administrative and management roles;

95.3 develop communication strategies and materials for use by other hospitals in raising staff and community awareness of family violence and the role of health professionals; and

95.4 develop a capacity-building model that is sustainable and potentially transferable to other hospitals in Victoria.

96. The Victorian Government is progressing its planning for the next phase of this initiative. This is likely to include distribution of a project kit to Victorian hospitals, as well as support mechanisms for local uptake and adaptation of the project kit in other Victorian hospitals supported through allocation of up to a further $250,000 in 2015-16.

CRAF training

97. CRAF training is funded by the Department and delivered through the Domestic Violence Resource Centre Victoria. It is freely available to health professionals. I understand that Mr Scott Widmer of the Department has addressed the topic of this training in his statement.

Some other examples of guidelines and training for health professionals

98. To actively promote uptake of CRAF by general practitioners, the Department provided some funding to Networking Health Victoria to amend their training in relation to family violence to align it with the CRAF in the context of the specific needs of general practitioners. General practitioners also have access to the Royal Australian College of General Practitioners' clinical guidelines, including *Abuse and Violence: Working With our Patients in*

[redacted]

General Practice which was recently updated to include a chapter on elder abuse.

99. The *Vulnerable Babies, Children and Young People at Risk of Harm: Best Practice Framework for Acute Health Services* (2006) (**Attachment FD-17**) was developed as a resource for health services to assist them in providing an effective health service response to vulnerable children exposed to child abuse or neglect, including family violence. This framework focusses on early intervention and the need to consider cumulative harm when assessing concerns about the safety, health and wellbeing of vulnerable children. The framework also provides organisational guidance to enable health services to establish policies, procedures and training, to identify and respond to suspected child abuse or neglect. Among other things, the resource provides guidance to emergency departments in relation to identification of and responses to family violence affecting children. The Department's *Intervention Guide for Vulnerable Babies, Children and Young People* (**Attachment FD-18**) sets out specific guidance for health services in identifying and responding to children and young people where child abuse is suspected.

General practice and emergency care

100. As observed at paragraph 82 above, health professionals are well positioned to identify individuals affected by family violence and respond to their needs. General practitioners and emergency departments are an early point of contact for such people who are seeking assistance. Although emergency departments are designed to deliver short episodes of time-critical care (before deciding if someone will be admitted, referred elsewhere or discharged home), general practice is designed to have an ongoing role with patients to promote and manage their health needs (including as a gatekeeper to specialist care).

101. Statewide policies have therefore focussed on establishing linkages between primary care providers, emergency departments and other parts of the hospital and broader health and social services system to improve access to optimal health care when and where it is needed. Linking primary and emergency care with each other and with other services promotes earlier intervention and also facilitates access to acute care where appropriate.

[redacted]

102. The *Guidelines for the Victorian Emergency Department Care Coordination Program* (2009) (**Attachment FD-19**) were produced by the then Department of Human Services. They include guidance on the role of acute health services in working with specialist family violence and sexual assault services to identify, assess and manage victims or people at risk. They require health services to:

102.1 use risk assessment and risk management frameworks including but not limited to those issued by the Department for initial assessment and screening; and

102.2 undertake comprehensive needs assessment of individuals presenting to an emergency department.

103. Aligning risk screening and assessment approaches is intended to ensure timely and appropriate identification of the individual's care needs, and to ensure that the 'first door is the right door'. The level of risk is then used to determine safety plans within the emergency department and make appropriate referrals to care coordination and specialist services. In cases of sexual assault, these referral mechanisms might include:

103.1 referral to CASA workers who provide services on an in-reach basis to the hospital;

103.2 referral to Multi-Disciplinary Centres (**MDCs**) which co-locate members from the Victoria Police Sexual Offences and Child Abuse Investigation Teams, child protection practitioners, community health nurses and CASA counsellor/advocates, to provide an integrated response to victims of sexual assault.

Women's and children's health services

104. The Department's Victorian Women's Health Program provides funding for three statewide women's health services (including Women's Health Victoria) and eight regional women's health services. They also receive funding from the Office of Women's Affairs. The aim of the Victorian Women's Health Program is to improve the health and wellbeing of Victorian women, with an emphasis on those most vulnerable. The Program operates from a social model of health and acknowledges gender as a key determinant of health.

[redacted]

105. The Department has provided funding for women's health services to oversee the development and implementation of regional family violence primary prevention plans and associated initiatives. They are also funded to play a role in delivering family violence counselling services.

106. In addition, the Royal Women's Hospital and the Royal Children's Hospital (**RCH**) provide a leadership role in fostering and supporting the development and implementation of best practice in addressing family violence across the health system. As stated above, the second phase of the *Strengthening Hospital Responses to Family Violence* initiative is being led by the Royal Women's Hospital in partnership with Bendigo Health (following an initial pilot overseen by Our Watch). This initiative aims to develop a transferable model of practice and supporting tools, protocols and training resources for Victorian health services.

107. Under the *Framework for Vulnerable Babies, Children and Young People at Risk of Harm*, health services are encouraged to establish vulnerable children working groups or committees to raise the awareness of and improve systems within their health service for vulnerable children. For example, the RCH has a Vulnerable Children's Committee that brings together, across that hospital, forensic paediatric services, social workers and general medicine and emergency clinicians. The Committee seeks to identify greater opportunities to protect vulnerable children and young people. The Committee is responsible for the coordination of education and training for RCH staff regarding the management of vulnerable children, quality assurance including consistent approaches to patient pathways, and the development of relevant procedural guidelines. This work provides the leadership and direction for care of children at RCH and also across the system, through the development of standards and the promotion of policy for vulnerable children.

108. The RCH is also funded by the Department to provide the Victorian Forensic Paediatric Medical Service (**VFPMS**), which provides assessment of, and care for, abused, assaulted and neglected children and young people. The Department and VFPMS have jointly developed the online resource *Health Professionals Working Together To Keep Children Safe* to assist health professionals working in Victorian hospitals and community settings to identify

[redacted]

vulnerable children, respond to situations where abuse or neglect is suspected, and understand the child protection system.

Maternity and newborn programs

109. Maternity and Newborn services are delivered by a range of public health services and have a critical role in identifying and supporting vulnerable or at risk women and children. The Department has responsibility for the Maternity and Newborn Program. The Department's *Capability Framework for Victorian Maternity and Newborn Services* (2010) (**Attachment FD-20**) sets out six levels of care which might be provided by a health service in relation to maternity and newborn services. In respect of all levels of care, health services are required to provide support services which include:

109.1 family support services with established referral pathways and communication with ChildFIRST, Child Protection services and maternal and child health (**MCH**) nurses;

109.2 drug and alcohol services with established referral pathways to specialist services; and

109.3 mental health services with established referral pathways to specialist mental health practitioners and facilities.

110. These requirements are reinforced by the Department's *Postnatal Care Guidelines for Victorian Health Services* (2012) (**Attachment FD-21**). This document relevantly states that:

110.1 health services should establish and maintain effective linkages with other health services and community-based providers of maternity and newborn care to enable women to access appropriately qualified and skilled health professionals;

110.2 health services should ensure MCH services are appropriately notified of infants and children that are vulnerable, including those known to Child Protection and Placement and Family Services;

110.3 health services should ensure MCH services are appropriately notified of women who are vulnerable or disadvantaged or who have high needs; and

[redacted]

110.4 health services must take measures to ensure continuity of care between services to avoid gaps in care provision.

111. These guidelines also require that health services undertake a comprehensive assessment of factors that may impact on the health and wellbeing of women and their families and this assessment should be initiated during the antenatal care period and be ongoing during the postnatal period. The guidelines also refer to other relevant programs for identifying and supporting vulnerable women and children, including Koori Maternity Services and the Enhanced MCH service.

112. Victorian policy frameworks and guidance are aligned with the *National Evidence-Based Antenatal Care Guidelines* (2012) (http://www.health.gov.au/antenatal), which have been developed by the Commonwealth Government in collaboration with state and territory governments. These clinical practice guidelines contain two modules and, in particular:

112.1 Module one contains a section relating to assessment of, intervention in and responses to domestic violence and recommends, among other things, that:

(a) at the first antenatal visit, all women should be informed that asking about exposure to domestic violence is a routine part of antenatal care and such an enquiry should be made;

(b) such an enquiry should be made when alone with the woman, tailoring the approach to her individual situation and the practitioner's own skills and experience (such as, for example, using open-ended questions about the woman's perception of safety at home or using an assessment tool);

(c) practitioners should be aware of training programs that improve confidence and competency of health professionals in identifying and caring for women experiencing domestic violence;

(d) assistance to Aboriginal and Torres Strait Islander women who are experiencing domestic violence should be

[redacted]

appropriate to the woman and her community and involve an awareness of family and community structures and support; and

(e) practitioners should be aware of resources for domestic violence services in their community that can be called for urgent assistance and this may include local safe houses or the Strong Women Workers in their community; and

112.2 Module 2 addresses care in the second and third trimesters of pregnancy and provides guidance on core practices, lifestyle considerations, clinical assessments, common conditions and maternal health tests for healthy pregnant women.

113. Another program of relevance is the Healthy Mothers Healthy Babies, which is an antenatal program delivered through community health services in nine local government areas across outer metropolitan Melbourne. The program is funded by the Department and provides outreach and support to vulnerable women during pregnancy, including women living in insecure housing, living in poverty, with substance abuse issues, who have experienced family violence, refugees and women from culturally and linguistically diverse backgrounds, and Aboriginal women.

114. Communication and consented information-sharing between women and health and other professionals is supported by the Victorian Maternity Record which is designed to provide pregnant women with a standard printed maternity record of their pregnancy care and progress. The record encourages women's involvement in decisions regarding their own care and assists in improving communication between women's service and care providers. The maternal history and examination section of the record includes a record of Social/Other Issues including work/home/social relationships/domestic situations. The record also directs consideration to any support services that may be required postnatally.

115. In addition, the protocol *Continuity of Care: A Communication Protocol for Victorian Public Maternity Services and the Maternal and Child Health Service* (2004) (**Attachment FD-22**) provides for communication between maternity services and MCH services of assessment of risks to newborn children,

including risks associated with family violence. The protocol is currently being updated jointly by the Department and the Department of Education and Training. A draft updated protocol was released for public consultation in June 2015 with a view to finalising the protocol in 2015-16. A copy of the draft updated protocol is attached to this statement at **Attachment FD-23.** The draft protocol is currently under consultation with the sector and feedback has not yet been incorporated into the document.

Ambulance Victoria

116. If, in practice, Ambulance Victoria paramedics consider that they are treating a person who has been injured as a result of family violence, they will usually attempt to transport the person to hospital. The service recognises, however, that there are opportunities for improvement in the way in which patients experiencing family violence are identified and supported.

117. Ambulance Victoria has recently commenced work to develop, in collaboration with key stakeholders, a clinical practice guideline and policy framework to support the identification and management of patients who are either experiencing or at risk of family violence. Ambulance Victoria is also investigating opportunities to improve the identification of patients who may be experiencing family violence at the point of call taking. Ambulance Victoria is also considering opportunities to refer patients to appropriate support services if they are experiencing family violence and do not wish to be transferred to hospital. Initial conversations have been undertaken with Safe Futures and Victoria Police about this piece of work and opportunities for further collaboration.

118. The Department supports this strengthened focus on more tailored responses for people experiencing family violence and will be including specific action to be undertaken in 2015-16 by Ambulance Victoria as part of its Statement of Priorities actions. It will be expected that this work is completed in 2015-16 with the development of guidelines and/or protocols and its workforce provided with training prior to implementation.

119. Ambulance Victoria presently has processes in place when attending to vulnerable children who are at an increased risk of being subject to violence or

sexual exploitation. Among other things, Ambulance Victoria's clinical practice guidelines provide that, when attending and treating children:

> Paramedics should call the Police, if in their professional judgement there appear to be factors that place the young patient at increased risk, such as the patient:
>
> - is subject to violence (eg from a parent, guardian or care giver)
> - is likely to be or is in danger of sexual exploitation.
>
> In particular for children where:
>
> - the supply of drugs appears to be from a parent/guardian/ care giver
> - there is other evidence of child abuse/maltreatment or evidence of serious untreated injuries.

120. These guidelines are reviewed annually with consideration given to performance data, published evidence, and internal and external consultation. Responsibility for approving these Guidelines rests with the service's Medical Advisory Committee.

Community health services

121. Community health services are well positioned to respond to the challenges of their local client group in a holistic and coordinated way. This is particularly important in responding to family violence, where community health services have an increasing role in strengthening the interface between family violence, mental health, alcohol and drug, and primary care services.

122. As I have observed at paragraph 18 above, Victoria's network of 88 community health services also deliver services funded by the Department of Education and Training and the Department of Justice and Regulation. They can also be in receipt of Commonwealth funding through provision of some Medicare-funded general practice services.

123. In the 2014-15 financial year, State Government funding for community health services was approximately $138 million. This funding supports services to deliver health promotion, general counselling, allied health (audiology,

[redacted]

dietetics, physiotherapy, occupational therapy, podiatry, speech therapy) and community nursing services. Family violence can be a presenting issue for counselling services.

124. State-funded community health services are prioritised to population groups with known poor health status and subject to disadvantage. This includes people who are homeless or at risk of homelessness, refugees and asylum seekers, Aboriginal and Torres Strait Islander people, people with an intellectual disability or a serious mental illness, and children in out of home care. Funding is provided for the provision of direct care and for health promotion.

125. All community health services are expected to support the coordination of multiple services in meeting the holistic needs of clients. In order to do so, they are expected to use the Service Coordination Tool Templates (**SCTT**), which are a suite of templates developed to facilitate and support service coordination. The SCTT is a screening tool that supports the collection and recording of initial contact, initial needs identification, referral and coordinated care planning information in a standardised way. It is not a comprehensive assessment tool. The SCTT has a single-page screening tool for health and social needs (which includes a question to help identify family violence), and a record for accommodation and safety arrangements (which includes a section about family violence) for use as part of the initial needs identification process (**Attachment FD-24**). If family violence is identified, clients are referred to relevant services as appropriate.

126. Community health services often work in partnership and collaboration with other services. One example is the use of community health services to improve access to health services for children in out of home care.

127. Another example is the co-location of community health nurses in sexual assault multidisciplinary centres or MDCs (to which I have referred at paragraph 103 above). In this regard, five community health services have been funded to deliver community health nurses to six sites during normal business hours. The nursing service reflects a social model of health and wellbeing that complements and integrates with other services, providing care to victims/survivors in the short-to-medium term, followed by referral to appropriate community services. In particular, MDCs are presently

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operational in Seaford, Geelong, Mildura and Dandenong and MDCs in Bendigo and Morwell are expected to become operational this calendar year. To date, Monash Health has employed nurses for the Seaford and Dandenong MDCs. The appointment of community nurses at the other MDCs is expected to occur in 2015.

128. For victims of sexual assault, MDCs co-locate relevant agencies to promote integration. In addition to the community health nurse, co-located specialist professionals include members of Victoria Police Sexual Offences and Child Abuse Investigation Teams, Child Protection practitioners, forensic medical services, CASA counselors and advocates.

129. In relation to this new role for community health nurses, Monash Health has also been funded by the Department to employ a statewide nursing coordinator, who commenced in April 2015, to:

129.1 support community health services to deliver the community nursing service;

129.2 provide leadership across MDCs; and

129.3 support the sustainability of the model.

Aboriginal health programs

130. Aboriginal Community Controlled Health Organisations (**ACCHOs**) take a holistic approach to the health and wellbeing of Aboriginal people. ACCHOs receive both Commonwealth and State funding to address vulnerability and disadvantage in this population group. Key programs and initiatives include advocacy, education and awareness raising campaigns, men's programs, and health and social support services. Many also deliver family violence programs.

131. Within Victoria, some ACCHOs are members of Indigenous Family Violence Partnerships which oversee local implementation of the *Strong Culture, Strong Peoples, Strong Families: Towards a Safer Future for Indigenous Families and Communities – 10 year plan*. Some State-funded services which include specific initiatives for Aboriginal women and children and their families are:

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131.1 The *Bumps to Babes and Beyond* initiative was developed as a holistic, intensive and whole-of-family model of care and support for pregnant Aboriginal women aged 14 to 25. The initiative has a specific focus on engaging highly vulnerable and at-risk young women during their pregnancy and through to the first 18 months of a child's life. The initiative has successfully supported a number of women by providing support arrangements for families from the antenatal care phase through to early childhood. A project which builds on the experience of this model is now being implemented as the *Early Years Project* supported through Koolin Balit in all Aboriginal Community Controlled Health Services across the Loddon Mallee Region.

131.2 The *Aboriginal Best Start* initiative aims to improve the health, development, learning and wellbeing of Aboriginal children, with a strong emphasis on prevention and early involvement. Aboriginal Best Start develops partnerships between service providers and local Aboriginal communities to maximise outcomes for Aboriginal children by ensuring that all services encountered by a family are communicating with one another. Six projects established in areas with high Aboriginal populations across the State coordinate service providers such as maternal health services, kindergartens, health services, community health centres and schools.

131.3 The *Aboriginal In Home Support* program aims to improve outcomes for Aboriginal children. It provides an opportunity to take an integrated approach to optimising outcomes for all Aboriginal women and young children, building on the positive relationships established through the Koori Maternity Service program. There are currently six Aboriginal organisations delivering the In Home Support Program in Bairnsdale, Fitzroy, Geelong, Mildura, Shepparton and Swan Hill.

132. The Koori Maternity Service program was first funded in 2000 and developed by the Victorian Government in partnership with ACCHOs. It aims to improve access to culturally appropriate maternity care for women. The *Koori Maternity Service Guidelines 2015* are currently in draft and under

consultation by the sector (**Confidential Attachment FD-25**). Among other things, the draft guidelines presently provide that:

132.1 Koori Maternity Service staff have a key role to play in the care and protection of vulnerable children through the early identification of child abuse and neglect; and

132.2 ACCHO and health service boards and management should have systems in place to support their staff to identify vulnerable children, respond to situations where abuse or neglect are suspected, and fully understand the child protection system.

Elder abuse

133. Responding to elder abuse has been included by the Department in the annual Statement of Priorities entered into with health services, as one of the standard actions which health services could choose. In 2014, the Department wrote to chief executive officers of health services requesting copies of their elder abuse prevention and response protocols. The results of this request were that 40% of services responded by submitting appropriate policies and protocols and thereby indicating an understanding of elder abuse. The remaining services either incorrectly submitted policies and protocols for Commonwealth requirements for compulsory reporting of assaults and sexual assault (16%), or did not respond. A significant number of those services who responded correctly had participated in the training rolled out by Victoria University on behalf of the Department.

134. In this regard, the Department funded during 2010-12 delivery by Victoria University of training on elder abuse prevention. The training was delivered to over 7,000 people working in a range of community services, including staff in the aged care sector. Victoria University continues to offer elder abuse recognition and response training as a series of two standalone workshops aimed at workers in direct contact with, or supervising workers in direct contact with, older persons.

135. Elder abuse training has been included in the Home and Community Care training calendar as part of an online course on vulnerable people; and Goulbourn Valley Primary Care Partnership, Upper Hume Primary Care

Partnership and Domestic Violence Resource Centre have been granted copyright releases to deliver training using the Department's training materials.

136. In March 2015, the Department released an online version of the elder abuse prevention course. To date, over 800 people have registered for the course with strong participation by people working in general practice and aged care. The Department is currently working with the Royal Australian College of General Practitioners to develop its training materials in relation to elder abuse for use in general practice training.

137. Seniors Rights Victoria is otherwise funded by the Department and Victoria Legal Aid to promote awareness of elder abuse and provide expert advice and support to people experiencing elder abuse.

Local approaches and initiatives for addressing family violence

138. Health services, including hospitals, have developed a number of local initiatives to address family violence. A summary of information obtained by the Department from health services about these local initiatives is attached at **Confidential Attachment FD-26**. Some examples of these initiatives are as follows:

138.1 The Colac Area Health Vulnerable Babies and Families Committee oversees implementation of the Department's *Vulnerable babies, Children and Young People at Risk of Harm: Best Practice Framework for Acute Health Services*. This implementation includes use of a universal screening tool to identify vulnerable children for use in the emergency department. Colac Area Health is also a member of the Barwon Integrated Family Violence Alliance and its staff training includes VicHealth's *Preventing Violence Against Women* short course.

138.2 St Vincent's Health has operational policies and procedures regarding the management of family violence and the protection of children at risk of abuse or neglect. In 2013, St Vincent's Hospital Melbourne implemented a new hospital-wide policy, model of care and education framework to respond to elder abuse. This work was undertaken in line with the Victorian Government's *Elder Abuse Prevention Strategy*

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(2010) (**Attachment FD-27**) and *With Respect To Age: Practice Guidelines for Health and Community Agencies for the Prevention of Elder Abuse* (2009) (**Attachment FD-28**). A copy of a report of St Vincent's Hospital on its *Elder Abuse Prevention and Response Initiative* is attached to this statement as **Attachment FD-29.** In addition, there is, at the hospital, routine family violence screening of women accessing mental health services and drug and alcohol services, and targeted screening in the emergency department.

138.3 Monash Health is part of an Integrated Family Violence Partnership and has developed a Strategic Plan in relation to family violence. Monash has family violence related operational policies, procedures, training and resources for staff, including screening tools.

DATA COLLECTION AND MEASURING PERFORMANCE

139. In this statement, I have not referred in detail to data collection, information management and information sharing. I am aware that these matters are the subject of other evidence to be given by the Department and others to the Royal Commission.

140. At a high level, existing national and state approaches to measurement are primarily focussed on monitoring the achievement of targets or benchmarks and quantifying the relationship between health system inputs, outputs and outcomes. This is reflected in the *National Performance and Accountability Framework*, the *National Health Performance Framework*, and the *Victorian Performance Monitoring Framework*.

141. The Victorian Emergency Minimum Dataset (**VEMD**) includes de-identified demographic, administrative and clinical data detailing presentations at Victorian public hospitals within designated emergency departments. The VEMD includes a 'human intent' field for identifying sexual or other forms of assault, and neglect or maltreatment of a child or adult. However, data is not routinely analysed by the Department and is of limited utility in isolation of other data profiling a patient and his or her pathways through the system.

142. Linked longitudinal data analysis is critical to effective planning and evidence-based policy. Data linkage brings together information about people, places

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and events in a way that protects individual privacy. It can muster evidence held within disparate datasets to enable new and important questions central to policy and practice to be researched and answered. Victorian Data Linkages has been established in the Department to build this data linkage capability in Victoria while using specialised techniques to preserve privacy and data integrity.

143. Victoria Data Linkage is developing the Victorian Data Linkage Map containing the critical linked health and social service datasets that are now and could be in the future regularly used to meet business, planning, policy and research needs to support improved population health and well-being outcomes. Work will be progressed over the coming months with other relevant agencies including the Department of Justice and Regulation, the Department of Education and Training and Victoria Police to identify future opportunities.

144. The Victorian State Trauma Registry collects information on all major trauma patients from every hospital and health care facility managing major trauma patients in Victoria, including their outcomes at 6, 12 and 24 months after injury. The Victorian State Trauma Outcome Registry and Monitoring group from Monash University coordinates the Registry. The Victorian State Trauma Registry's summary report for the period from 1 July 2013 to 30 June 2014 is the thirteenth summary report of the Registry. Data collected during these thirteen years have enabled trend monitoring in major trauma incidence, severity, management and outcomes. Trauma cases attributable to family violence are not routinely analysed or reported but this has been identified as an area of opportunity for the State Trauma Committee to consider.

145. Although Ambulance Victoria does not currently have a mandatory family violence field/flag in either its call-taking system or information recording system, this information may be captured in the 'comments' field. Ambulance Victoria is currently reviewing what level of data is captured overall and then plans, in relation to family violence, to implement interventions or data triggers in collaboration with Safe Futures Foundation and potentially Victoria Police.

OPPORTUNITIES

146. Victoria's health system sits within a broader approach to family violence prevention and responses. Some women's health services, Primary Care

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Partnerships and local governments have prevention of violence against women as a priority. Similarly, State and municipal level Public Health and Wellbeing plans (as required under the *Public Health and Wellbeing Act 2008* (Vic.)) include prevention initiatives.

147. In the 2014-15 financial year and again in 2015-16, each Statement of Priorities for health services makes addressing family violence a priority for the system. In 2014-15, there was a particular focus on elder abuse prevention, which included health services reporting to the Department on their implementation plans as well as participating in Department-funded training. Under the Statement of Priorities in 2015-16, health services are required to demonstrate how they are working to prevent, identify and better respond to family violence, particularly in vulnerable or high risk groups (see paragraph 44 above).

148. Although the health sector has been working to develop more systematic processes for identifying and responding to family violence, it is acknowledged that there is still a way to go in ensuring that best practice is core practice across the system. This includes ensuring that the workforce is well equipped and supported to identify and respond to family violence, including clear protocols and referral pathways, and collaborative, cross-sector service models.

149. This must be underpinned by more systematic approaches to sharing appropriate information between service providers and monitoring outcomes for those people experiencing or at risk of family violence.

150. The Department recognises the need to evaluate and invest in campaigns and community projects that have demonstrated benefit in addressing the underlying risk factors for family violence, including gender inequity. Both VicHealth and the Royal Women's Hospital have a statewide leadership role in this area, and this will continue to be fostered.

151. A key system-level initiative is the family violence Risk Assessment and Management Panels (**RAMPs**) which are currently being established across the State. RAMPs aim to improve responses to women at serious and imminent risk from family violence. RAMPs will include representatives from

the health sector including clinical mental health services and drug and alcohol services.

152. Primary Care Partnerships in the North and West metropolitan region commenced a 12-month pilot project in May 2015, to assist member agencies to develop a more streamlined, coordinated and integrated response to women and children experiencing family violence. The project is called *Identifying and Responding to Family Violence*. A copy of the project proposal is attached to this statement at **Attachment FD-30**. Key elements of the project include supporting use of the single-page screening tool, delivering tailored family violence training for staff and developing resources including information on referral pathways. The findings from this pilot will inform the activities of other PCPs and their members.

153. There is an opportunity to strengthen the alignment of risk assessment tools and frameworks that support screening for family violence. This could extend to alignment across individual organisations, between health services, and with specialist family violence services to promote a common language and continuity of approaches that foster a 'no wrong door' response and earlier intervention as part of routine practice.

154. I have referred above to the CRAF. This is an important development in terms of such a whole of system approach. Further exploration of opportunities to target screening to vulnerable groups, particularly at high risk periods in their life, is also warranted.

155. There is an opportunity to expand best practice models and programs in health services for responding to family violence. As stated above, the Department has recently established an agreement with the Royal Women's Hospital to explore the transferability of the data management systems, protocols, tools and resources developed under the *Strengthening Hospital Responses to Family Violence* initiative, with a view to supporting its uptake across Victorian hospitals. In addition, the Department is in early negotiations with St Vincent's Health to explore the potential transferability of its *Elder Abuse Prevention and Response initiative* (see **Attachment FD-29**), which provides a comprehensive clinical governance framework with supporting training and resources for staff.

[redacted]

156. The Department remains engaged in a continuous process of review and systemic improvement of the health system's response to family violence. Accordingly, the Department will further assess its policies and procedure in light of findings and recommendations of the Royal Commission.

Signed by **FRANCES MARIE DIVER**)

at Melbourne)

this 3rd day of August 2015)

[redacted]

An Australian legal practitioner
within the meaning of the
Legal Profession Uniform Law (Victoria)

Before me [redacted]

[redacted]