Strengthening Hospital Responses to Family Violence

Guide 2
Service Model Implementation

A practical guide for establishing and implementing the service model
First Edition
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- Western Health
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Note: This version of the SHRFV series of Guides, published in January 2016, is a first edition and will be further refined and expanded following feedback and input from hospitals during 2016.
Introduction

This practical guide is designed to provide a methodology to support hospitals to plan and successfully implement the Strengthening Hospital Responses to Family Violence (SHRFV) Service Model.

Below are the three suggested stages for managing this project:

- Stage 1 - Project Establishment
- Stage 2 - Project Execution
- Stage 3 - Project Transition and Sustainability

Anticipated timelines of implementation will vary across hospitals and this will largely be dependent on work that may have already been initiated within your organisation. Any work that has preceded the implementation of this service model will enable your organisation to progress sooner to long term maintenance sustainability. For those hospitals where this is relatively new, it is indicated (dependent on size, demographics and resources) that implementation could take 18-24 months.

*Please see Guide 1, ‘Introduction’ for more information.*

Transition and sustainability requires careful planning and is best considered early in Phase 1. The Transition Plan is prepared towards the end of the rollout in the identified clinical area at which time the Implementation Team should have a good understanding of some of the challenges already encountered and where success lies.

This Guide should be read in conjunction with *Guide 1 – Service Model and Toolkit* and *Guide 3 - Service Model Training Package*
Abbreviations

CEO Chief Executive Officer
CRAF Family Violence Risk Assessment and Risk Management Framework, also known as the Common Risk Assessment Framework
DHHS Department of Health and Human Services
ED Emergency Department
FV Family violence
FVIO Family violence intervention order
HIS Health Information Services
IFVS Integrated Family Violence Sector
ICT Information, Communication and Technology
IPV Intimate Partner Violence
MOU Memorandum of Understanding
MH Mental Health
OH&S Occupational Health and Safety
PAS Patient Administration System
PP&Gs Policies, Procedures and Guidelines
RIC Family Violence Regional Integration Coordinator
SHRFV Strengthening Hospitals Response to Family Violence
The Women’s The Royal Women’s Hospital
WHO World Health Organisation
VAED Victorian Admitted Episodes Dataset
VCAT Victorian Civil and Administrative Tribunal
VEMD Victorian Emergency Minimum Dataset
VINAH Victorian Non-Admitted Health dataset
## Definition of terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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| Child Abuse                 | Is any action, or lack of action, that significantly harms the child’s physical, psychological or emotional health and development. The Child Youth and Families Act 2005 (VIC) enables consideration of the pattern and history of harm and the impacts on a child’s safety, stability and development. There is an overwhelming body of evidence which indicates that chronic neglect, abuse and family violence are harmful and have a cumulative and detrimental effect on a child’s development. Child abuse can occur within a single incident or on multiple occasions and is categorised in the following manner:  
1. Physical abuse  
2. Sexual abuse  
3. Emotional/psychological abuse  
| Elder abuse                 | Any act occurring within a relationship where there is an implication of trust, which results in harm to an older person. Abuse may be physical, sexual, financial, psychological, social and/or neglect. |
| Family Violence (FV)        | As per the family Violence Protection Act 2008 (Vic); behaviour by a person towards a family member of that person if that behaviour—  
is physically or sexually abusive; or  
is emotionally or psychologically abusive; or  
is economically abusive; or  
is threatening; or  
is coercive; or  
in any other way controls or dominates the family member and causes that family member to feel fear for the safety or wellbeing of that family member or another person; or  
behaviour by a person that causes a child to hear or witness, or otherwise be exposed to the effects of, behaviour referred to in paragraph (a)  
The Act also contains a preamble that states that ‘The Parliament also recognises the following features of family violence—  
that while anyone can be a victim or perpetrator of family violence, family violence is predominantly committed by men against women, children and other vulnerable persons’.  
that children who are exposed to the effects of family violence are particularly vulnerable and exposure to family violence may have a serious impact on children's current and future physical, psychological and emotional wellbeing;  

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that family violence—(i) affects the entire community; and (ii) occurs in all areas of society, regardless of location, socioeconomic and health status, age, culture, gender, sexual identity, ability, ethnicity or religion; that family violence extends beyond physical and sexual violence and may involve emotional or psychological abuse and economic abuse; that family violence may involve overt or subtle exploitation of power imbalances and may consist of isolated incidents or patterns of abuse over a period of time.

**Family member**

As per the Family Violence Protection Act 2008 (VIC)

- a) a person who is, or has been, the relevant person's spouse or domestic partner; or
- b) a person who has, or has had, an intimate personal relationship with the relevant person; or
- c) a person who is, or has been, a relative of the relevant person; or
- d) a child who normally or regularly resides with the relevant person or has previously resided with the relevant person on a normal or regular basis; or
- e) a child of a person who has, or has had, an intimate personal relationship with the relevant person.

(2) For the purposes of subsections (1)(b) and (1)(e), a relationship may be an intimate personal relationship whether or not it is sexual in nature.

(3) For the purposes of this Act, a "family member" of a person (the "relevant person") also includes any other person whom the relevant person regards or regarded as being like a family member if it is or was reasonable to regard the other person as being like a family member having regard to the circumstances of the relationship, including the following—

- a) the nature of the social and emotional ties between the relevant person and the other person;
- b) whether the relevant person and the other person live together or relate together in a home environment;
- c) the reputation of the relationship as being like family in the relevant person's and the other person's community;
- d) the cultural recognition of the relationship as being like family in the relevant person's or other person's community;
- e) the duration of the relationship between the relevant person and the other person and the frequency of contact;
- f) any financial dependence or interdependence between the relevant person or other person;
- g) any other form of dependence or interdependence between the relevant person and the other person;
- h) the provision of any responsibility or care, whether paid or unpaid, between the relevant person and the other person;
- i) the provision of sustenance or support between the relevant person and the other person.

i) the provision of sustenance or support between the relevant person and the other person.
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>person and the other person.</td>
<td>Example: A relationship between a person with a disability and the person’s carer may over time have come to approximate the type of relationship that would exist between family members.</td>
</tr>
<tr>
<td>(4)</td>
<td>For the purposes of subsection (3), in deciding whether a person is a family member of a relevant person the relationship between the persons must be considered in its entirety.</td>
</tr>
<tr>
<td>Intimate Partner Violence</td>
<td>This refers to behaviour by an intimate partner that causes “physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours”. 3 This definition covers violence by both current and ex-partners and other intimate partners.</td>
</tr>
<tr>
<td>Partner</td>
<td>A person’s spouse or domestic partner irrespective of gender</td>
</tr>
<tr>
<td>Example</td>
<td>Two women living together in an intimate personal relationship</td>
</tr>
<tr>
<td>Victim/survivor</td>
<td>A term used in conventional practice and throughout this document to refer to those that may have identified as experiencing family violence. It is in recognition of language on our patterns and behaviours. ‘Victim’ is commonly understood as emphasising the innocence of one against who a crime is perpetrated, the term ‘survivor’ alone does not alert us to this major actor.4</td>
</tr>
<tr>
<td>Gender equitable organisation</td>
<td>A gender equitable organisation is a workplace as one in which women and men are equally represented, valued and rewarded5. For example committing to regularly report on pay equity, family friendly policies that promote men and women in the caring roles outside of work and gender equitable leadership. In the area of primary prevention, working to promote gender equity and respectful relationships are ways that an organisation can address the key determinants of violence against women.</td>
</tr>
<tr>
<td>Guidelines or protocols</td>
<td>Also known as standard procedures</td>
</tr>
<tr>
<td>Patient</td>
<td>Generally refers to the consumer/client of the health service who is experiencing violence, also known as the ‘victim/survivor’.</td>
</tr>
<tr>
<td>Policy</td>
<td>Statements of principle that guide decision-making and service delivery</td>
</tr>
<tr>
<td>Procedures</td>
<td>More detailed instructions about how policies should be carried out by</td>
</tr>
</tbody>
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**Primary Prevention**

Refers to the efforts of society to promote, protect and sustain the health of the population. In family violence and violence against women it involves seeking to prevent violence before it occurs by addressing the root causes; the unequal distribution of power between men and women, rigid gender roles and attitudes, norms, behaviours and practices that support violence.\(^6\)

A holistic approach to prevention involves also challenging structural inequalities, negative stereotypes and discrimination, including those based on Aboriginality, disability, class and socio-economic status, ethnicity, religion, sexual identity and refugee status\(^7\).

<table>
<thead>
<tr>
<th>Secondary prevention</th>
<th>Secondary prevention within the context of family violence and violence against women is targeted towards individuals and groups who display early signs of perpetrating violent behaviour or of being subject to violence(^8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tertiary prevention</td>
<td>Tertiary prevention in relation to family violence and violence against women involves providing intervention, support and treatment to those who are affected by violence or to those who use violence. Intervention strategies are implemented after violence occurs(^9).</td>
</tr>
<tr>
<td>Response</td>
<td>Action or strategy to prevent or minimise risks of family violence from re-occurring.</td>
</tr>
<tr>
<td>Sensitive Practice</td>
<td>The framework(^10) for a way of operating as a health professional that is designed to increase a patient’s sense of safety, respect and control, ultimately reducing the risk of re-traumatisation for victim/survivors, who may chose not to disclose it.</td>
</tr>
<tr>
<td>Sensitive Inquiry</td>
<td>An approach of routinely asking patient’s about their experience(s) of family violence underpinned by a framework of sensitive practice. The approach used here is based on the World Health Organization’s clinical(^11) enquiry approach and Health Canada’s principles of sensitive practice, which drew on lessons from victim/survivors of child hood sexual abuse.(^12)</td>
</tr>
<tr>
<td>Sexual assault</td>
<td>Sexual assault or sexual violence is as any sexualised behaviour perpetrated against a victim/survivor whereby informed consent is not</td>
</tr>
</tbody>
</table>

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\(^8\) Ibid.

\(^9\) Ibid.


given by the victim/survivor. It can include rape, sexual assault with implements, being forced to watch or engage in pornography, enforced prostitution, and being made to have sex with friends of the perpetrator.13

About the service model

The service model has six key elements:

1. Create cross hospital leadership and momentum\textsuperscript{14}
   a. Strategies to engage the hospital personnel from top down

2. Changing culture\textsuperscript{15}
   a. Identifying the prevailing culture within the hospital and building capacity for change
   b. Partnerships with hospital consumers who have experienced violence
   c. Ensuring staff safety

3. Laying the foundation through Policy, Procedures and Guidelines\textsuperscript{16}
   a. Adaption or development of relevant policies, protocols and guidelines to identify and document consumers’ experiences of family violence and any subsequent referrals. To ensure the hospital’s role is complementary, these will need to recognise the role and expertise of Family Violence services, and that any implemented policies, protocols and guidelines integrate with the family violence system.

4. Building capacity and capability\textsuperscript{17}
   a. Increasing the competence of key staff within the hospital environment to better identify and respond to family violence
   b. Provision of clinical training aimed at improving the knowledge and ability of staff to identify and respond to family violence; and to increase understanding of risk assessment and family violence.
   c. Provide support to clinicians to undertake the work

5. Building partnerships with wider community and family violence sector\textsuperscript{18}
   a. Supporting consumer participation and consultation in the process.
   b. Building partnership with the wider community and family violence sector
   c. Increasing referrals of victim/survivors within the health service and to external services

6. Evidence leads best practice\textsuperscript{19}
   a. Improving data collection on identification and responses to victim/survivors of family violence, within the hospital context
   b. Evaluating the success of the model into the hospital environment

\textsuperscript{15} Ibid
\textsuperscript{16} Ibid
\textsuperscript{17} Ibid
\textsuperscript{18} Ibid
\textsuperscript{19} Ibid
How to use this guide
Applying a project management approach to implementing the model into the hospital environment will support project outcomes to be delivered within a designated timeframe, to a defined quality and with a given level of resources.

This Guide offers project management tools, templates and checklists to plan, implement and track the progress of the project to successful implementation.

These tools are included at the back of this Guide. Many of these templates have been partially populated with indicative information that may assist you with implementation.

In recognition that each hospital environment is unique and has its own culture and systems, the information contained in this Guide is designed to support full implementation and ongoing sustainability of this approach to responding to family violence.

Setting up for success
A number of factors have been identified to promote successful implementation. These are:

- **Hospital commitment, investment and support** – A commitment to this project from top down will significantly enhance the outcomes and benefits that can be realised. It is a significant investment of resources for any hospital.

- **Past history of related initiatives** – Any previous initiatives undertaken by the hospital in the area or related area of family violence (for example, Victoria’s Family Violence Risk Assessment and Risk Management Framework (CRAF) training that is offered in Victoria) or its state or territory equivalent could act as a foundation for the implementation of this model.

- **A committed multidisciplinary implementation team** – Nominating key staff across programs and divisions who are committed to the project and to attending Implementation Team meetings to guide the project in achieving its objectives is crucial. In addition, inviting external representatives from family violence services, government partners and peak bodies in your area will promote greater coordination between the hospital and community services. Finally the assignment or appointment of a dedicated Family Violence Project Coordinator to lead the project.

- **Visibility** – The project will benefit from having visibility and an ongoing presence across the hospital. A strong communication strategy and plan, developed in consultation with relevant stakeholders (including consumers), will help keep the profile of the training and topic visible.

- **Project Management approach** - A project management plan will help with communications to stakeholders (including consumers) to undertake actions in the right order, identify key resources, keep a clear end date in mind and implement the project successfully.

What can go wrong with estimating resourcing?
These are some of the common mistakes (including consumers) that can lead to inaccurate estimates:

- Not understanding what is involved to complete a task, e.g. failure to estimate the Family Violence Project Coordinator’s hours for project start up time
- Failing to estimate the cost of rollout to nurses/midwives
- Under estimating ongoing costs to embed the model into the hospital environment
Achieving short term outcomes

For this project a set of short term outcomes have been identified for realisation by the project end. The indicators of success of these short term outcomes are:

- **Policies, Procedures and Guidelines** - Adaptation or development of relevant policies, procedures, guidelines and assessment forms, toolkits and resources.

- **Capability** - Increased competence of key staff within the hospital environment to better identify and respond to family violence measured through attendance and evaluation of training (e.g. clinical training, VicHealth Leadership training, Bystander training).

- **Data** - Evidence of formalised quality process and improved data collection.

- **Linkages** - Expansion of links with organisations that provide family violence services.

Tools to assist

A number of tools have been identified to assist at each stage of the project.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Project Tools</th>
</tr>
</thead>
</table>
| 1     | Project Establishment Setting up the project | Briefing Paper  
Implementation Team Terms of Reference  
Meetings Schedule  
Meeting Agenda  
Project Budget Projection  
Risk Management Plan  
Communication Plan  
Gantt Chart  
Family Violence Project Coordinator Position Description  
Evaluation Methodology |
| 2     | Project Execution Implementing, Monitoring and Reporting on progress | Meeting Agenda  
Minutes and Actions  
Progress Report |
| 3     | Project Transition and Sustainability | Transition Plan for continued rollout |
Three project stages

Stage 1 - Project establishment

One of the first tasks you might consider to commence this project is to appoint a Family Violence Project Coordinator and establish a governance structure that would provide guidance to the Coordinator.

This stage is characterised by detailed planning and requires strong buy-in at the hospital executive level and senior manager level.

Activities in this stage include:

a) Establish a Governance Structure
   i. Assign or appoint a Family Violence Project Coordinator
   ii. Appoint an Executive Sponsor
   iii. Confirm membership of the Implementation Team
   iv. Establish Terms of Reference
   v. Confirm hospital scope of project implementation and systematic roll out

b) Develop a Project Plan for the phased approach with timelines

c) Determine resource commitment

d) Determine what reports are required

e) Develop a Risk Management Plan

f) Develop a Communications Plan

g) Develop a Project Evaluation Methodology

a. Establish a Governance Structure

Governance is about accountability, appropriate decision making, clarity of roles and responsibilities, and developing effective processes and systems to oversee the successful implementation of the service model into the hospital environment.

(i) Assign or appoint a Family Violence (FV) Project Coordinator

Assigning or appointing a dedicated FV Project Coordinator (part or fulltime) will assist the hospital to establish the project and rollout the training. This role may be seconded an existing position, as discussed below. The level of EFT funding to this position will depend upon the size, complexity, funding source and priority and how well this project has been embedded within the hospital at that point.

A staff member who already has family violence as a portfolio role e.g. a Social Work Team Leader or a Clinical staff member who has training, capacity and interest in this area and project management skills would be ideal.

The FV Project Coordinator is responsible for coordinating all of the activities to successfully implement the model across the hospital environment. This includes monitoring and reporting on progress and overseeing the collection of data.

The FV Project Coordinator would report to the Implementation Team.

See Attachment A for sample Position Description for this role.
(ii) Appoint an Executive Sponsor

Appointing an Executive Sponsor is important to support the role of the FV Project Coordinator and to make decisions on behalf of the hospital. The Executive Sponsor will need to be available to meet with the FV Project Coordinator at regular intervals to discuss how the implementation is going and identify any issues that require executive endorsement, for example seeking ratification of any policies or protocols developed. The Executive Sponsor would be involved from the start of the project and would be available in a formal supervisory arrangement for the FV Project Coordinator throughout the project. The Executive Sponsor would also Chair the Implementation Team meetings.

The role of the Executive Sponsor is to:

- Ensure resolution of issues escalated by the FV Project Coordinator.
- Sponsor the communications program; communicate the project goals across the hospital to increase visibility of the project.
- Ensure availability of essential project resources.
- Review and approve changes to plans, priorities, deliverables and schedule.
- Gain agreement amongst the stakeholders (including consumers) when differences of opinion occur.
- Chair the Implementation Team meetings.
- Encourage stakeholder (including consumers) involvement and build and maintain their ongoing commitment.
- Advise the FV Project Coordinator of protocols, political issues and potential sensitivities.
- Report progress to the hospital executive.
Item 1 – Proposed Hospital Governance Structure for this project is as follows:

Quick Checklist – Governance Readiness
Q 1 – Are all members that need to be at the table signed up?
Q 2 – Are governance and shared management arrangements clear?
Q 3 – Are the Executive and practitioner (operational level) managers linked in?
Q 4 – Is there common values and a set of common language about the project?
Q 5 – How clear are the roles and accountabilities?
Q 6 – Does the governance group have ‘authority’ to make decisions?
Q 7 – Are there processes for members to report back to their areas on the progress of the project?
(iii) Confirm membership of the Implementation Team

An Implementation Team that has sufficient ‘authority’ will be able to:

- Build hospital engagement and buy-in.
- Provide clear direction and control over the use of resources and time.
- Ensure alignment of activities across the hospital to enable successful implementation.
- Engage external partners and stakeholders (including consumers) but more specifically those in the broader family violence sector across the region.
- Undertake some of the tasks relevant to their area.
- Provide a two way communication conduit to and from colleagues in their respective areas.

Implementation Team membership might include those listed in item 1, and dependent on the nature of your hospital’s size, location and demographic include external representation such as local government, peak bodies and broader members of the family violence sector.

The degree to which the hospital endorses and actively supports the introduction of the model will impact on its successful implementation at the clinical staff level and capacity to embed practices into everyday work.

Hence a diverse membership with both staff and senior managers across departments involved will promote stronger adoption of the project particularly for development and then rollout of key policy and practice changes.

Engaging with departments where family violence is core or ancillary business, promotes clinical leadership and promotes the project and its key messages.

It is suggested that initially, garnering support and buy-in from senior managers who are receptive and most likely to be supportive of introducing organisational and practice change will facilitate positive influence with other key managers.

Inviting external family violence service representatives onto the Implementation Team:

- Increases the agencies’ understanding of the hospital’s approach.
- Increases the hospital’s understanding of the role and responsibilities of specialist family violence services.
- Enables the agencies to make presentations to the Implementation Team to raise awareness of family violence and family violence interventions.
- Enables the agencies to be involved with the teaching team.

As part of establishing the Implementation Team, the FV Project Coordinator will be required to undertake the following activities:

(iv) Establish Implementation Team Terms of Reference (ToR)

The ToR document describes operational working arrangements for the Implementation Team. The ToR is generally drafted prior to the first meeting of the group and tabled for discussion and endorsement at the meeting.

The Terms of Reference might include:

- Purpose
- Role
- Membership
- Meeting schedule
- Administration and other systems support

Tip for ensuring all views are canvassed

Never underestimate the importance of informal discussions with all levels of staff and in keeping all stakeholders (including consumers) informed.
These Terms of Reference may need to be formally endorsed at the hospital executive.

See Attachment B for an example of ToR

(v) Confirm hospital scope

The Implementation Team will need to advise the hospital executive on the options for scope of the implementation. Scope refers to the boundaries of the work that is to be undertaken such as defining the implementation area. Detailing what is out of scope can be really valuable so as not to lose time and resources on tasks that aren’t required.

It is critical that the hospital executive is involved in defining the extent to which the model is adopted in your hospital and that this is understood by all areas of the hospital.

This will ensure appropriate resources are committed to the project. Once the scope has been determined for the initial rollout, the second stage of rollout can be encompassed in the ongoing sustainability plan.

In terms of defining scope in the pilot, Bendigo Health was focused on three primary roll out areas: the Emergency Department, Women’s Health and Mental Health services whilst the Women’s chose their Emergency Department.

A way forward for the Executive Sponsor, FV Project Coordinator and Implementation Team to generate interest in this model, might involve a formal briefing paper with an accompanying presentation to the hospital executive team to seek their endorsement.

Hospital executive endorsement is the key to a successful implementation.

b. Develop a project plan or rollout plan with timelines

A common failure of any project is an overestimation of capacity and an underestimation of resource requirements. A good strategy to adopt is to develop a staged rollout of the activities and this Guide has been designed to support this approach.

The list of activities against a timeline is referred to as a Gantt chart and is the internal management document for the project. This document assists the FV Project Coordinator and Implementation Team to check actual progress against planned activities and timelines.

Each step of the project is represented by a line placed on the chart in the time period when it is to be undertaken. When completed the chart shows the minimum total time for the project, the proper sequence of steps and which steps can be commenced or underway at the same time.

The Gantt chart also identifies who has responsibility for completing each task or activity and this should be determined by the FV Project Coordinator and Implementation Team as early as possible.

Estimating Time

- A few rules will help ensure that an accurate and realistic estimate is produced for each activity (and task):
- Assume that resources will only be productive for 80 per cent of the time.
- People are generally optimistic and often underestimate how long tasks will take.
- Make use of other people’s experiences and your own – contact The Women’s FV Project Coordinator.
Always build in a contingency for problem solving, meetings and other unexpected events.

Note the Gantt chart attached has a 15 month timeline that can be adjusted to meet the requirements of your hospital.

See Attachment C for a Gantt chart template for this project.

c. Determine resource commitment

This section should list the resource requirements needed for your hospital to proceed with this project.

Determining an accurate estimate of resources will assist the hospital executive to consider the investment the hospital will make to the project. Areas to consider are human resources; physical and technical resources; training costs; backfill; financial and ongoing support.

See Attachment D for a Project Budget Projection Template

d. Determine reporting requirements

There is a range of monitoring and reporting methods available depending upon the size, profile and requirements of the hospital. For this project, less formal methods can be used which include regular update meetings between the FV Project Coordinator and Executive Sponsor to discuss the progress and any issues arising in implementation. This can be combined with monthly progress report updates to the Implementation Team and a quarterly progress report to the hospital executive.

A simple written monthly report on how the project is progressing may suffice for your hospital. Key areas for inclusion might be:

- Status of work being performed compared to the plan (timelines)
- Volume of work being completed
- Quality of work being completed
- Resources utilised
- Issues encountered
- Updated risk assessment
- General comments
- How the project is being received across the hospital

The next question to decide is to whom the reporting is to and from:

- FV Project Coordinator to Executive Sponsor
- FV Project Coordinator to Implementation Team
- Executive Sponsor to hospital executive

See Attachment E – Agenda for reporting to Implementation Team
e. Develop a risk management plan

In the context of project management, risk refers to any factor (or threat) that may affect adversely the successful completion of the project in terms of delivery of its outputs and securing of outcomes, or adverse effects on resourcing, time, cost and quality\(^2\)\(^0\).

The purpose of risk management is to ensure levels of risk and uncertainty are properly managed so that the project is successfully completed.

A Risk Management Plan summarises the proposed risk management approach for the project and includes:

- A description of the risk
- The impact should this event actually occur
- The probability of its occurrence
- A summary of the planned response should the event occur
- A summary of the mitigation (the actions taken in advance to reduce the probability and / or impact of the event)
- Who is responsible for managing the risk
- How often the plan will be reviewed

**See Attachment F for a Risk Management Plan template**

f. Develop a communications plan

The impact of project timing and the importance of strong intra-organisation communication are important considerations for your hospital. Communication is important when developing communications plans and in organising communications activities and events. It is vital for not only the successful introduction of the model into the hospital setting but to embed the clinical practice changes anticipated from this project. Often people affected by the change need to hear about change on multiple occasions and in multiple forms.

A good communication strategy is initiated at the commencement of the project, with pre-agreed processes for seeking input and approval from relevant stakeholders and consumers, and keeping key representatives and personnel informed. Identifying the target audiences, crafting clear messages, identifying clear communication roles and rules, and then effectively communicating these messages to the various audiences within the hospital will increase the likelihood of the success of implementation.

A good communication flow keeps hospital staff informed about what is going on; it promotes trust and creates a more productive environment for implementation. The Implementation Team is responsible for approving the Communication Plan. All media releases, communications, and publications should follow your hospital standards for promotion.

Hints

- Identify who is responsible for communication between all sites and areas of the hospital.
- Identify what information needs to be shared and with whom.

Promotion Ideas

- Launch of the service model
- Signing of Memorandum of Understanding (MoU) between the hospital and Family Violence service provider partners formalising referral processes.
- Hospital executive and staff CEO forum to introduce the model.
- Announcement via hospitals e-bulletin of the models introduction.
- Establishing a dedicated website or page on your website.
- Delivering presentations of local data and information to executive, manager and staff meetings raises the awareness and the call to action within the organisation.
- Promotions in internal media, such as newsletters and posters, and promotion in external local media, such as interviews with executive/senior managers create cross hospital leadership and momentum.
- Engagement and participation in sector days of relevance i.e. between 25 November, the International Day for the Elimination of Violence against Women (and White Ribbon Day), to 10 December, Human Rights Day; which are the 16 Days of Activism Against Gender-Based Violence.

See Attachment G - Communication Plan
g. Develop a project evaluation approach

The purpose of developing an evaluation approach prior to implementation of the project enables baseline data and progress of a project to be identified and tracked21. “Program evaluation is the systematic collection of information about the activities, characteristics, and results of programs to make judgments about the program, improve or further develop program effectiveness, inform decisions about future programming, and/or increase understanding”.22

Key techniques, program logic or methodologies for evaluating the success of your hospital adopting a model for strengthening responses to family violence are outlined below, and it would be advisable that hospitals consider what form of evaluation methodology or program logic will best suit the context of the domains being evaluated23,24, and what processes are involved in doing so.

There are a multitude of approaches to evaluation, and in the experience of the Women’s and Bendigo Health in piloting the Strengthening Hospital Responses to Family Violence Project pilot, a mixed methods evaluation was applied. Below are options that vary in resourcing, complexity and time. Common types of evaluation include25:

- **Developmental evaluation** is undertaken during the development phase to assess the ideal form of the initiative and to contribute to a learning process. The purpose is to develop, test and improve the project, program or policy.

- **Formative** evaluation is usually undertaken during the implementation phase to gain an insight into the impact and processes of the initiative in its early stages and to contribute to a learning process. The purpose is to support and improve the management, implementation and development of the project, program or policy.

- **Process** evaluation monitors how a project or program has been implemented. It concentrates on what is being done within a service, project or program. It measures the activities and services against what was expected, who the program is reaching, and to some degree the quality of the activities.

- **Impact** evaluation is usually carried out when the project, program or policy has been in place for some time to study its effectiveness and to determine its overall impact. These evaluations are typically used to assist in allocating resources or enhance public accountability.

- **Meta evaluation** is concerned with the value or worth of an overall strategy. For example, the individual evaluations of each sub-program become the data for the meta analysis which examines the relationships between findings across various studies.

Evaluation tools26 include a range of resources used in the design, planning and implementation of an evaluation. These include:

- **Evaluation framework** outlines the plan for implementing the evaluation. It commonly includes the project logic, evaluation questions, data requirements and collection processes, and the relevant data analysis tools.

- **Project Logic** unpacks the logic underpinning the program or project that is being evaluated. The project logic assists the evaluation to be clear about the activities,

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21 Kwok WL 2013, Evaluating preventing violence against women initiatives: A participatory and learning-oriented approach for primary prevention in Victoria, Victorian Health Promotion Foundation, Melbourne, Australia
23 Ibid
26 Ibid.
outputs and expected outcomes of the program, particularly the short and medium term outcomes.

- **Data collection tools** comprise the range of activities used to collect data to inform the evaluation and can include: key informant interviews and focus groups; observations; feedback sheets, questionnaires and surveys; document review; partnership analysis; and practice reflection.

For the purposes of initial evaluation of this work, quantitative measures to evaluate might include:

- Baseline and post-implementation surveys on the level of knowledge and confidence of staff to identify family violence.
- Number of increased identification of incidents recorded in the hospitals database.
- Number of referrals to specialist family violence service.
- Set of policies, protocols and guidelines developed.

**Staff Survey**

A great way to see change and measure the success of the program is to survey the clinical staff of the rollout areas on their level of knowledge and confidence in family violence before and after the training.

Questions for consideration might include:

- Level of current knowledge about the prevalence, causes and impact on of family violence
- Level of confidence in identifying a patient/client who is experiencing family violence
- Level of confidence in identifying clinical risk indicators of family violence
- Level of knowledge on the roles and responsibilities of the hospital in identifying family violence, preliminary risk assessment (where appropriate) and supporting the clinical needs of consumers experiencing family violence
- Level of knowledge on the comprehensive risk assessment and risk management roles and responsibilities (providing service response) of the specialist family violence services in supporting consumers experiencing family violence
- Level of knowledge of referral agencies and referral process
- Barriers to applying knowledge in practice
- Enablers to applying knowledge in practice

The collection and observation of qualitative data will provide an insight into the culture of the hospital and its adoption of the changed practice. This could be conducted by way of focus groups, informed interviews, online discussion forums etc. Observation and attending staff meetings of the clinical staff and non-clinical staff who have completed various levels of training might provide an indication of how well the training has been integrated into everyday practice. Engagement with key stakeholders and consumers will also be a sound way to collect qualitative data, but will require that stringent ethical processes are met in order to so safely.

More in depth evaluations require time, effort and resourcing. They are offered here as a reference only.

**See Attachment H – Project Process Evaluation Questions**
Stage 2 - Project execution

The Execution stage involves implementing, monitoring and tracking the key tasks and activities as identified in the Gantt chart and monitoring progress against set timelines.

This is the time that the FV Project Coordinator and Implementation Team are fully engaged. Some aspects to consider are:

- Managing issues that arise.
- Marketing the project to the hospital staff and executive (ongoing).
- Clinical Service Managers at the frontline to promote the project e.g. promoting the family violence training to key staff.
- Achieving project objectives – on time and on budget.
- Reporting at scheduled meetings as coordinated by the FV Project Coordinator.

The role of the FV Project Coordinator during this phase is to concentrate on completing those tasks identified in the Gantt chart by the due date and monitor the work tasks to be completed by other key staff.

Specifically the tasks identified in the Gantt chart to be undertaken by the FV Project Coordinator and the Implementation Team include:

- **Promotion of model**
  - Identify, schedule and attend key team meetings across hospital departments with in scope areas.

- **Family Violence assessment, response & referral policy and procedure**
  - Conduct a gap analysis of current policies, procedures and guidelines.
  - Clarify staff roles and responsibilities in identification and clinical response to consumer experiencing family violence
  - Clarify specialist FV services roles and responsibilities in comprehensive risk assessment and risk management.
  - Adapt or develop a generic FV - Assessment, Response & Referral Policy & Procedure or Protocol.
  - Seek Implementation Team input.
  - Seek hospital executive endorsement (through Executive Sponsor).
  - Seek to strengthen internal policies and procedures for supporting staff experiencing, or working with those experiencing, family violence.

- **Family violence service mapping**
  - Mechanisms for consumer partnerships, including co-design, advice, consultation and engagement (i.e. how might you engage the sector)
  - Conduct a service mapping of family violence service providers/agencies in local area.
  - Identify, schedule and attend any family violence network meetings or similar in your region, state or territory to introduce model and process.

- **Database development**
  - Map existing database system/s for baseline FV data
  - Prepare quarterly auditing of data set
  - Prepare reports on incidents of FV presentations
• Coordinate training delivery
  - Meet with Nurse Unit Managers (NUM) in targeted roll out areas – discuss and agree delivery dates; participant numbers; venue and delivery mode.
  - Advertise and promote training sessions to targeted roll out areas.
  - Schedule training dates and venue.
  - Nominate second Trainers or training pool.
  - Evaluate impact of training delivery.

• Project reporting
  - Prepare monthly progress reports for Implementation Team.
  - Prepare quarterly progress reports for hospital executive.

See Attachment I – Project Progress Report

The FV Project Coordinator’s role in promoting a culture of practice change

The intent of successful change management is to engage the people who are affected by the change, to get them to come on the journey from the present to the desired state. This includes both internal staff – management, nursing, midwifery and clinical staff, and external family violence services staff who will all be involved in either adopting new practices in responding to family violence (internal staff) or strengthening links between hospital, consumers and the FV sector (external staff).

The FV Project Coordinator plays an active role in fostering change and acting as a catalyst in the implementation of change. Change is a continuous process, not a single event, and includes managing changes to the organisational culture including people, business processes, staff skills and knowledge, as well as policies and procedures.

Inviting one or two FV sector representatives onto the Implementation Team will strengthen this engagement and inviting other FV service representatives to contribute to development of key documentation will also promote buy in.

Key activities for the FV Project Coordinator at the commencement of, and during implementation of the project are:
  - Identifying change agents from within the organisation to support the change.
  - Building and maintaining effective project sponsorship.
  - Acknowledging and managing resistance.
  - Using collaborative approaches.
  - Executing a staged implementation, and
  - Monitoring and evaluating.

Suggested project activities

The Women's facilitated a Prevention of Violence Against Women (PVAW) ‘summer series’ of informative sessions for key hospital staff delivered by a range of family violence agencies about their organisation, service provision and referral pathways.

This idea provided staff with an opportunity to gain further understanding about engaging in variable family violence issues and complexities from agencies with specific demographic expertise such as Aboriginal and Torres Strait Islander communities and New Migrant Communities.

White Ribbon Day, celebrated annually on 25 November, is a national, male led campaign to end men’s violence against women. In recent years the Women’s and Bendigo Health have held staff events on White Ribbon Day. For more information visit www.whiteribbon.org.au
Hints during implementation

- Regular visits by the Coordinator to the roll-out areas to reinforce education and support staff on the frontline.
- Schedule sessions at double staffing time/handover to discuss any issues, barriers and enablers with frontline staff.
- Recruit and schedule time to meet with Clinical Champions to maintain momentum in the roll out area and address any issues on site.

Stage 3 - Project transition and sustainability

Stage 3 is about reviewing progress to date in preparation for embedding the service model across all clinical areas of your hospital, and further strengthening your hospitals relationship with the family violence sector.

Transition planning for full rollout identifies the tools, techniques, and processes that will assist your hospital to do this.

Key activities will include:

- Reviewing progress to date
  - One of the key tasks is to evaluate how well staff have adopted the family violence policy and protocols into their clinical practice and their level of knowledge of and confidence in their practice
  - This can be evaluated through conducting a pre and post survey amongst nurses and midwives to compare rates of adoption;
  - Capturing any 'lessons learned' to date
- Prepare a Transition Plan
- Full Rollout of training across the hospital as per the Transition Plan

Planning for Transition

The purpose of transition planning is to layout the tasks and activities that need to be in place to ensure the sustainability of the model in the hospital environment and to ensure that practices continue.

The planning process is generally captured in a Transition Plan and is designed to prepare the hospital environment for sustainability of the new ‘operational environment’. The plan is used to describe how the full rollout will be implemented and how these changes will be monitored.

A Transition Plan is drafted by the FV Project Coordinator and signed off by the Executive Sponsor for presentation to the hospital executive for endorsement.

Typically, the thinking for transition commences in Stage 2 – Project Execution as the Implementation Team considers longer term outcomes such as:

- Identification - Increased identification of victims of family violence within the hospital context.
- Response - Increased referral of victims within the health service and to external services.
- Prevention - Increased knowledge and skills of key staff in addressing the underlying causes of family violence through planning and implementing primary prevention initiatives.
- Evidence - Building the evidence base on prevalence rates and presentations to hospitals by women and children experiencing family violence.
A further long term goal for the hospital consistent with its organisational planning might include a focus on the services they offer to their staff in the workplace and this could include:

- Introduction of specific Family Violence Leave, either through standalone policies or through their Enterprise Bargaining Agreement.
- Reviewing your hospitals Employment Assistance Programs to include provisions to support staff who are experiencing or have survived family violence or staff who may be experiencing vicarious trauma through supporting clients who are experiencing family violence.
- Undertaking a gender equity audit to understand how your hospital promotes gender equity and respectful relationships as an employer and service provider.
- Incorporating the role of your hospital in identifying and responding to family violence as a key performance indicator (KPI) and include in the strategic planning process.

See Attachment J – Transition Plan Template

Summary

The intent of this Guide is to provide a staged process to enable this key piece of work to be planned and implemented into the hospital setting with ease. Stages identify natural points to assess the effort underway and to adjust activities to suit the hospital environment.

Inevitably issues will arise with projects that involve organisational change. This project has many internal stakeholders and some external stakeholders (including consumers), each with their own expectations and ideas about how the hospital might strengthen its response to family violence.

Applying this project management framework and adapting it to suit the needs of your hospital, will promote a planned and well executed process.

A Project Management Quality checklist is attached for the FV Project Coordinator to tick off tasks as they are achieved to provide a sense of achievement for all involved in the change agenda.

See Attachment K - Project Management Quality Assurance Checklist
**Position Description**

**Title**  
FV Project Coordinator

**Classification**  
Social Worker GR 4 or equivalent

**Term**  
Full-time (negotiable), fixed term 1 year

**Agreement**  
Victorian Public Health Sector (Health and Allied Services, Managers and Administrative Officers) Multiple Enterprise Agreement

**Responsible to**  
[name Executive]

**About Our Hospital**

(Insert information about your hospital)

[Insert Hospital Name] Declaration/Values

[Insert Hospital Name] Declaration reflects the principles and philosophies fundamental to our hospital:

[Insert name the Department/Unit that the FV Project Coordinator will sit]

**Position Purpose**

This position has responsibility, under the direction of the [name senior executive] for managing the introduction of the Service model which is aimed at strengthening our hospitals capacity to prevent and respond to violence against women.

Introducing the model will involve increasing staff competence and thereby improving practice enabling better identification and responses to victim/survivors experiencing family violence, and to optimise their relationship with our local family violence system.

The project will also build capacity of selected hospital staff to plan and implement initiatives aiming to prevent violence before it starts, and develop a sustainable plan for primary prevention within the organisation.

The project has access to a number of resources and tools for use in this project. These include a number of Guides to project manage and implement the model.

Project activities will include a range of tasks including coordination of activities to ensure outcomes are delivered, monitoring and review of activities to ensure risks and timelines are managed, and development of project documents, including plans, schedules, communication strategies, project reports, and presentations.

**Responsibilities & Major Activities**

- Apply sound project management methodology and clinical expertise to the project including:
  - Provide expertise and advice to (insert hospital) on identifying and responding to FV
  - Assist in establishing the Implementation Team
  - Populate the detailed Gantt Chart, Communication Plan and Risk Management Plan in accordance with the timeframes set out by the hospital or as set by the senior executive
  - Provide regular and frequent reports to the executive sponsor and Implementation Team on progress against the project
• Co-ordinate Implementation Team meetings; provide agendas, reports and minutes for all project meetings
• Ensure appropriate communication with all stakeholders (including consumers) in accordance with the communication plan (this may include preparing and/or giving presentations on the project)

**Key Selection Criteria - Experience/Qualifications/Competencies**

**Essential**
1. Demonstrated experience in leading and managing projects with multiple stakeholders (including consumers)
2. Extensive experience in the area of family violence and/or prevention of violence against women
3. A tertiary qualification in Social Work, Health or other related field
4. Ability to work effectively in both a team environment and independently when required
5. Written and verbal skills
6. Demonstrated capacity to communicate effectively with a diversity of stakeholders (including consumers)
7. Experience working in hospitals as a health professional or project manager

**Desirable**
1. Experience in driving cultural change or organisation-wide development programs, preferably in a hospital setting
2. A formal qualification in project management
3. Knowledge and understanding of adult learning and education
4. Confidence in presenting to small and large audiences

Employee Name
Employee Signature Date:

Manager Name
Manager Signature Date:
Attachment B - Implementation Team Terms of Reference (ToR)

TERMS OF REFERENCE

Date:

1. Purpose
   The Implementation Team will oversee the successful implementation of the service model.

2. Objectives
   The Implementation Team sets out to:
   - build hospital engagement and buy-in
   - provide clear direction and control over the use of resources and time
   - ensure alignment of activities across the hospital to enable successful implementation
   - engage external partners in the broader family violence sector across the region

3. Membership
   - The Implementation Team membership might include the following hospital staff:
     - Senior hospital executive e.g. Clinical Operations or similar
     - Service Director(s)/Manager(s) e.g. Social work (Chief Social Worker), Nursing/Midwifery
     - Nurse/Midwifery Unit Manager(s) and Medical Director(s) of target roll out areas
     - Up to 3 senior clinicians/clinical leads from the target roll out areas
     - Clinical Education representative
     - Health Records and Information Manager
     - IT/Patient Administration System Manager
     - Business Performance Reporting
     - Family Violence from local area
     - FV Project Coordinator

4. Meeting Process
   **Coordination of meetings, minutes and agenda**
   The FV Project Coordinator will coordinate monthly meetings and send out a meeting schedule to all members. The FV Project Coordinator will take minutes and actions and write the agendas for the meetings. All meetings will be held (state room and location).

   The Executive Sponsor will chair the meetings.

   **Decision Making**
   All recommendations passed by the Implementation Team are to be signed off by the Executive Sponsor. Recommendations that carry a budgetary item (additional to the identified budget) will require hospital executive approval.

5. Responsibilities and Functions
   The Implementation Team members will seek to:
   - Support, engage, canvass and represent their respective hospital departments or agencies
- Disseminate information to its constituents in an efficient and timely manner.
- Ensure two way consultation and communication between the team and its constituent group
- Undertake allocated tasks as discussed at each meeting
Determining an accurate estimate of resources will assist the hospital executive to consider the investment the hospital will make to the project.

Areas to consider are human resources; physical and technical resources; financial and ongoing support (beyond the initial deliverables).

**Human Resources**

The following table includes examples of the resource requirement for a potential project (include internal and external resources). Staffing for the project can be sourced from across programs.

<table>
<thead>
<tr>
<th>Role</th>
<th>Skills required</th>
<th>FTE Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>FV Project Coordinator</td>
<td>Experienced Project Manager with knowledge of family violence</td>
<td>Up to 1 FTE</td>
</tr>
</tbody>
</table>

**Physical & Technical Resources**

List any physical or technical resources required (e.g. access to hospital training rooms, laptops or workstations).

<table>
<thead>
<tr>
<th>Resource</th>
<th>Length of time required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting room for training session</td>
<td>Nursing Handover times – up to 10 sessions over a period of 2 months</td>
</tr>
<tr>
<td>Training backfill</td>
<td></td>
</tr>
</tbody>
</table>

**Financial**

List all major items to be purchased to complete this project. An example has been included below. All minor items (e.g. brochures) should be incorporated within the financial section later in this document.

<table>
<thead>
<tr>
<th>Item</th>
<th>Expected supplier</th>
<th>$ amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promotional Brochures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refreshments for building partnerships with external agency meetings – family violence</td>
<td>Hospital caterer</td>
<td></td>
</tr>
</tbody>
</table>

**Ongoing Support**

The following table should list any ongoing support required once the project has been completed. This section should be completed in conjunction with scope boundaries. Some examples have been included.

<table>
<thead>
<tr>
<th>Hospital Division</th>
<th>Area of Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Education and Clinical Operations</td>
<td>Training new nurses and midwives</td>
</tr>
<tr>
<td>Information Technology</td>
<td>Help Desk support</td>
</tr>
</tbody>
</table>
**Attachment E – Agenda for reporting to Implementation Team**

**Agenda for reporting to Implementation Team**

**Implementation Team Meeting Agenda**

**Project Name:**

**FV Project Coordinator:**

Agenda for the meeting scheduled <Day> <Date> <Month><Year> to be held from <Start time> – <End time> in <Room>, <Campus>

1. **Attendance:** List members
2. **Apologies:** List apologies
3. **Minutes from the Previous Meeting**
4. **Matters Arising from the Previous Meeting**
5. **Agenda item 1 – Progress Report**
   - Progress from last report
   - Communications Plan
   - Risk Management Plan
   - Issues identified
   - Budget
   - General comments
     - How the project is being received across the hospital
     - Level of engagement of the family violence sector agencies
   - Next major deliverables/milestones
6. **Next meeting**
7. **Other Business**

<table>
<thead>
<tr>
<th>Action Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date</strong></td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Next meeting:** scheduled for <Day> <Date> <Month><Year> to be held from <Start time> – <End time> in <Room>
# Attachment F – Risk Management Plan

A full description of risks and the potential consequences should be gathered through investigations such as seeking input from your Executive Sponsor; Implementation Team and clinical staff. These risks should be rated for ‘Likelihood’ and ‘Consequence’ to gain a Risk Rating.

**Key**

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Description</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extreme</td>
<td>Example - if the project outcomes were compromised leaving the hospital without a model for strengthening responses to family violence or jeopardising a patient’s safety due to poor execution</td>
<td>Almost certain Is expected to occur in most circumstances</td>
</tr>
<tr>
<td>Major</td>
<td>Example - significant impact on one or more project outcomes</td>
<td>Likely Will probably occur in most circumstances</td>
</tr>
<tr>
<td>Moderate</td>
<td>Example - resource commitment being underestimated</td>
<td>Possible Could occur at some time</td>
</tr>
<tr>
<td>Low</td>
<td>Example – Implementation Team member absence</td>
<td>Unlikely Is unlikely to occur</td>
</tr>
<tr>
<td>Negligible</td>
<td>Delayed timeline that does not affect the overall schedule</td>
<td>Rare May only occur in exceptional circumstances</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk No</th>
<th>Risk Description</th>
<th>Potential Consequences</th>
<th>Controls &amp; Treatments</th>
<th>Likelihood</th>
<th>Consequences</th>
<th>Risk Rating</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Size of change program for size of hospital is too ambitious</td>
<td>Poor or incomplete implementation Loss of momentum by hospital staff</td>
<td>Robust project plan developed with clear tasks and activities identified Realistic resource budget developed</td>
<td>Likely</td>
<td>Major</td>
<td>Extreme</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Lack of sufficient resources to implement the Model</td>
<td>Detailed scoping undertaken early to identify resource requirements Realistic plan developed to secure resource requirements</td>
<td></td>
<td>Almost certain</td>
<td>Major</td>
<td>Extreme</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Attachment G – Communication Plan**

The Communication Plan outlines how the FV Project Coordinator and Implementation Team will promote and keep all key hospital stakeholders (executive, departments in scope and relevant clinical staff) up to date on the projects progress. External stakeholders (inclusive of consumers) are also identified in this plan. It is both a promotional tool and reporting tool.

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Issues related to this stakeholder</th>
<th>Communications Objectives</th>
<th>Activities</th>
<th>Who to Action</th>
<th>How Often/When</th>
<th>Costs</th>
</tr>
</thead>
</table>
| Internal: Hospital Executive | Critical for projects success to engage hospital executive                                          | Endorsement of project to proceed          | Executive Briefing<br>  
  - Draft statement of intent<br>  
  - key short term outcomes desired by your hospital<br>  
  - options for scope of the implementation<br>  
  - departments in scope for training | Executive Sponsor<br>  
  FV Project Coordinator to assist in development of briefing | At planning phase | Nil                          |
| External: Family Violence (FV) Agencies, consumers, DHHS | Family violence intervention within the health sector is reliant on collaboration with FV services | To seek support of community FV agencies in form of referral pathways for people who disclose abuse to health care staff | Invite FV agency representatives to be on Implementation Team<br>  
  Support local community activities in relation to FV | FV Project Coordinator<br>  
  Legal Counsel to assist in development of MoU | Meetings as per ToR | Costs to attend or sitting fee? |
Attachment H – Project Evaluation Form

Below are a number of questions that the Implementation Team might discuss as a way to identify lessons learned and formally close the project. Not all questions need answering, rather the questions can be negotiated and prioritised with stakeholders (including consumers).

Process questions:

*Did we do what we said we would do (in time, on budget)?*

1. Were the project milestones completed on schedule?
2. How close to budget was final project cost?
3. If additional work was required, what was this?
4. Did the project achieve what it set out to do?

*What did we produce (outputs)?*

5. What tools and techniques were developed that will be useful for other hospitals?
6. What technological advances were made on this project?

*Who did we reach?*

7. Uptake of training/tools or related resources?

*What did we learn along the way?*

8. What did we learn about scheduling/budgeting/writing specifications that will help us on our next project?
9. What did we learn about how well the hospital embraced change?
10. What did we learn about reporting to hospital executive that will be useful for other hospitals?
11. What did we learn about implementation across divisions?
12. What recommendations do we have for ongoing implementation to embed practices around responding to family violence?
13. What lessons did we learn from our dealings with the integrated family violence services?
14. If we had the opportunity to do the project over, what would we do differently?

*What were the impacts of the project? Intended and untended effects*

15. Is there evidence that staff are better equipped to identify and respond to family violence? (confidence, capacity, increased prevalence or referrals?)
16. What were the unintended impacts of the project? Positive (eg. related activities generated) or negative (impacts of high referral rates to other services).
Attachment I – Project Progress Report

Project Name: 

Executive Sponsor: 

FV Project Coordinator: 

Project Objective: 

1. Reporting Period
(Insert date from last meeting) to (insert current date)

2. Overall Project Status
Provide brief explanation of the status of the project

| Is your project on track (green); moving to off track (yellow); off track (red) |
|-------------------------------|----------------|------------------|
| Green                         | Yellow         | Red              |

3. Project Status Report Summary
Provide a brief statement of project performance against deliverables and milestones.

4. Budget
Provide a brief statement of project performance against deliverables and milestones.

| Is your project on track (green); moving to off track (yellow); off track (red) |
|-------------------------------|----------------|------------------|
| Green                         | Yellow         | Red              |

Brief explanation of budget expenditure (insert budget information)

5. Updated Risk Assessment
Identify any changes in risk status to the previous report.

6. General Comments
Include any general comments that may support / enhance / add to the above sections. Things to note in this section may include:
- Issues encountered
- How the project is being received across the hospital
- Level of engagement of the family violence sector agencies
7. **Recommendations**

*Where no recommendations are raised for endorsement, this section should state that 'the Implementation Team note the Progress Report.'*

<table>
<thead>
<tr>
<th>Report prepared by:</th>
<th>Insert name here</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>(for acceptance)</td>
<td>(Insert Project Title) FV Project Coordinator</td>
<td></td>
</tr>
<tr>
<td>Accepted:</td>
<td></td>
<td>Date</td>
</tr>
<tr>
<td>(for release)</td>
<td>(Insert Project Title) Executive Sponsor</td>
<td></td>
</tr>
</tbody>
</table>
Attachment J – Transition Plan

The purpose of transition planning is to detail the tasks and activities that need to be undertaken to ensure the sustainability of the model in the hospital environment and to ensure that practices continue.

The Transition Plan identifies how this will be managed and identifies in addition to the tasks, the tools, techniques, and processes that are needed to continue the momentum for embedding the service model across all areas in your hospital and continuing to strengthen your hospital's relationship with the family violence sector.

1. Current Situation

This section describes the current hospital environment post Stage 1 – Project Establishment and Stage 2 – Project Execution. This may include the number of hospital staff trained; the development of policy and procedures etc.

2. Risks and Contingencies

This section outlines the risks faced by the transition process. The Risk Management Plan template used in the project can be refreshed to identify any known risks that may impact on embedding the service model into clinical practice. This may include resourcing, data collection challenges etc.

3. Strategies

This section identifies the strategies and tools to be used to promote the transition and how it might impact on other systems in the hospital such as Continuing Professional Development opportunities; the current database, clinical practice and more broadly, the family violence sector.

Other questions that the strategies might address include - how will the transition be undertaken; what arrangements and checks and balances will need to be in place to guarantee sustainability?

4. Transition Schedule, Tasks and Activities

This section outlines the timelines and tasks required for successfully transitioning the service model into everyday hospital practice, and in achieving the long term outcomes.

5. Transition Resources

This section outlines the specific resources needed to complete the transition, such as identifying a person who will ensure training for new nurses and midwives is scheduled in the education calendar; monthly data is collated, analysed and reported to hospital executive and other tasks etc.

6. Reporting and Communication Procedures

Define the ongoing reporting and communication procedures within and external to your hospital that are required.

Good communication is essential to inform internal and external stakeholders (including consumers) regarding the hospitals progress in implementing the change agenda. Failure to communicate may result in stakeholders (including consumers) not understanding the desired changes.

7. Document Approval

The Executive Sponsor signs off the Transition Plan and presents this to the hospital executive for endorsement.
## Attachment K - Project Management Quality Assurance Checklist

### Strengthening Hospital Responses to Family Violence in your Hospital

<table>
<thead>
<tr>
<th>Quality issue</th>
<th>Yes, no or n/a</th>
<th>Attach documentation and make comments below</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase 1 - Project Establishment</strong></td>
<td></td>
<td></td>
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<tr>
<td>Has a written briefing been prepared and signed off by the hospital executive that sets out:</td>
<td></td>
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<tr>
<td>• Rationale for project</td>
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<tr>
<td>• Project goals and objectives</td>
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<tr>
<td>• Scope of work?</td>
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<tr>
<td>• Project ‘fit’ with the hospital’s strategies?</td>
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<tr>
<td>• Proposed Governance Structure</td>
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<tr>
<td>o Executive Sponsor?</td>
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<tr>
<td>o FV Project Coordinator</td>
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<tr>
<td>• Background or reference material?</td>
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<tr>
<td>• Expected timeframe and phases?</td>
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<tr>
<td>• Expected costs, benefits and risks?</td>
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<tr>
<td>• Activities to be undertaken against timelines e.g. Gantt Chart</td>
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<tr>
<td>Has the hospital developed an Opening Statement?</td>
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<tr>
<td><strong>Phase 2 - Project Execution</strong></td>
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<tr>
<td>Are regular Implementation Team meetings held to discuss progress?</td>
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<tr>
<td>Are regular monthly progress reports presented at monthly Implementation Team Meetings?</td>
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<tr>
<td><strong>Phase 3 - Project Transition and Sustainability</strong></td>
<td></td>
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<tr>
<td>Has senior management committed further resourcing for rollout?</td>
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<tr>
<td>Has a communication strategy been developed to keep hospital staff and external stakeholders (including consumers) informed of progress?</td>
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<tr>
<td>Is the Implementation Team membership is suited to ongoing rollout?</td>
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<tr>
<td>How will the hospital evaluate the success of the rollout?</td>
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</tbody>
</table>