CHILD PROTECTION ALERT SYSTEM WITHIN HEALTH

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Executive Summary

In the New Zealand Health Strategy, addressing family violence is a priority health issue[1]. The Ministry of Health's Family Violence Intervention Guidelines; Child and Partner Abuse[2] provide a framework for the health sector to respond to family violence. A key component of this strategy is for healthcare providers to screen all adult women for family violence, by direct questioning. For children, however, there is no validated screening tool. In the absence of such a tool, healthcare providers must identify and respond to child abuse and neglect based on signs and symptoms of abuse. Both approaches require significant changes in the attitude and behaviour of clinical staff. To achieve these changes towards sound child protection intervention within clinical practice, a 'systems approach' is necessary.

Since 2000, more than one third of New Zealand District Health Boards (DHBs) have developed procedures to draw the clinician's attention to children presenting to hospital when previous child protection concerns have been identified. These child protection alert systems have been established using variable criteria and all but two operate internally. In 2005, the Paediatric Society of New Zealand (PSNZ) began working towards standardisation of this procedure between the DHBs. This paper highlights progress to date, issues impacting on implementation and a plan for progressing the establishment of a nationally consistent child protection alert system.

This paper is based on a position paper of the PSNZ[3], which supports the establishment of such a system. The Privacy and Children's Commissioners, the Ministry of Health, the Ministry of Social Development and the NZ Police all support the system in principle.

The system includes involvement of a specialist multidisciplinary team in each DHB, policies and procedures, workforce development for clinicians and quality improvement activities such as a process and outcome evaluation. Consultation on key ethical, legal and procedural issues such as stigma, privacy, alerts on siblings and removal of alerts has occurred and positions have been agreed. Further consultation will take place as more DHBs become involved in implementation.

The preferred location for lodging the child protection alert system is the National Health Index Medical Warning System (MWS). Following a formal Privacy Impact Assessment, the Ministry of Health has approved the use of the MWS for this purpose.

A nationally consistent child protection alert system is achievable and would enhance information sharing between DHBs. The system has national and local level support and its implementation would be consistent with national recommendations regarding effective child protection intervention. The outcome of implementing such a system should be enhanced practice and improved child safety.

Definition

"Child" refers to any person 0-16 years of age up until their 17th birthday. It also includes the unborn child. Therefore, 'child' in this document refers to the unborn, baby, infant, child and young person within this age range.

PART 1: Introduction

Participants in development of this model

The PSNZ is an independent society of health professionals throughout New Zealand, who daily deliver health care services to children and young people. The Society includes almost all practising paediatricians in New Zealand, and also includes paediatric surgeons, general practitioners, paediatric dentists, child health nurses, midwives, allied health professionals (such as dieticians, physiotherapists, occupational therapists, speech language therapists, play specialists and pharmacists), child mental health professionals from several disciplines and social workers. The current membership of the Society is 478.

The Child Protection Special Interest Group (SIG) is a sub-group of PSNZ members with a special interest in the provision of services to children affected by abuse and neglect. Current membership of the SIG is 121.

The Ministry of Health Violence Intervention Program funds a network of Child Protection and Family Violence Co-ordinators in every District Health Board in New Zealand.

Background

The New Zealand Health Strategy made it clear that addressing family violence, including child and partner abuse, is one of the key priorities in population health[1]. The Ministry of Health's Family Violence Intervention Guidelines; Child and Partner Abuse (2002)[2] provide a clear indication of the expected health sector response to family violence. Healthcare providers are recommended to screen all adult women for family violence, by direct questioning. For children, in the absence of a validated screening tool, the recommendation is to identify and respond to child abuse and neglect based on signs and symptoms of abuse.

These guidelines cannot be implemented without significant changes in the attitude and behaviour of many health professionals. Front line health providers working with issues of child abuse recognise that a systems approach is required to achieve these changes. This involves the support of senior management, comprehensive policies, standardised documentation, access to senior staff for consultation, effective systems to share information, workforce development and quality improvement activities such as audit and evaluation.

Over the last ten years, several New Zealand DHBs have developed procedures to draw clinicians' attention to previous child protection concerns in children presenting to hospital.

At the same time, there are various non-standardised procedures in each DHB to record/flag and access clinical alerts such as Penicillin Allergy, Drug Reactions and colonisation with antibiotic-resistant bacteria.

The national Medical Warning System (MWS) is attached to the Ministry of Health, Sector Services National Health Index (NHI). The system "is designed to warn healthcare providers of the presence of any known risk factors that may be important when making clinical decisions about patient care" [4]. The advantage of the national system is that when DHBs access the NHI database, existing flags on the MWS can be downloaded, alerting the health provider in another DHB to the information. However, DHBs and other healthcare providers have inconsistent practices for adding information to and retrieving information from the national MWS.

A child protection alert system within health

A number of DHBs have developed a process to flag in their health information system the existence of child protection concerns, retrieve the information and act upon it appropriately. The process, now widely known within the health system as a "Child Protection Alert" has been established within seven DHBs providing, between them, healthcare services to slightly over half of the nation's children.

Dr McLaren conducted a survey in 2004 of the Child Protection Alert (CPA) systems operating within New Zealand DHBs. Six DHBs then had a Child Protection Alert (CPA) system. There were multiple systems operating, with variable criteria. In most cases DHBs maintained these systems internally, reducing the ability to communicate with other DHB CPA systems[5].

The Paediatric Society of New Zealand has for some time been working towards standardization of this procedure between the DHBs and is well on the way to achieving that objective.

Why do we need a child protection alert system within health?

Acts of child abuse are frequently not single events. Many children diagnosed with abuse have previous child protection concerns, evidence of old injury, or a history of being seen by health professionals with vague symptoms that in retrospect could have been indicators of abuse[6,7,8.]

Recent research suggests that only a minority of children who are seriously injured or die from abuse in New Zealand are known to the Department of Child Youth and Family Services (CYF)[9,10]. In contrast, it is almost certain that all are known to at least one healthcare provider. Most cases of serious abuse occur in infants and pre-verbal children, who are unable to tell others. Such abuse is under-diagnosed, in part because signs and symptoms are missed due to a lack of diagnostic suspicion. In addition, many children identified with care and protection concerns are very mobile – because their caregivers are mobile, or because they are passed from one set of caregivers to another. This mobility often includes moving between multiple DHBs. Investigations of child abuse deaths in NZ consistently highlight how important it is for health services to share information about children at risk, and how often this fails to happen[11,12].

A CPA system therefore helps ensure that medical and nursing staff become aware of serious child protection concerns that have already been expressed within the health system. To be most effective this information should be readily available[5]. Although both Police and Child Youth and Family maintain national electronic databases, these are not readily accessible to healthcare providers. Most significantly, a health provider is only likely to try and contact the statutory authorities if he or she already had a high level of concern that a child is at risk.

Why do we need a national child protection alert system?

New Zealand families are often mobile and this is particularly true of families where children are at risk of abuse and neglect. It is important that relevant information on children can be shared nationally. The logical next step in the development of the Child Protection Alert system is therefore for this information to be shared between DHBs by uploading the CPA onto the MWS. This would enable a clinician in any hospital to which a child presents to contact a clinician in the hospital where the CPA was first lodged, and ascertain in detail what the cause for concern was and whether it is relevant to the new presentation.

The PSNZ has been working towards a national Child Protection Alert system for several years, culminating in 2007 in the establishment of a working group to problem-solve key issues. It is anticipated that a staged rollout will be used for implementation. The

implementation will focus first on those DHBs that have an established CPA system and wish to align with the national system. The long-term objective is that all DHBs will take part.

The Ministry of Health Violence Intervention Programme has endorsed this objective, incorporating it into two assessment processes. Firstly, the Ministry's service specifications require DHBs to report on their establishment of a CPA system and engagement with the national process. Secondly, the national evaluation assessing DHBs' responsiveness to child abuse and neglect includes items about establishment of processes for local and national CPAs.

A CPA system has limitations. It is only an adjunct to the assessment of the child, not a diagnostic tool. If a child has an alert all subsequent injuries should not be presumed to be a result of abuse. Likewise, a child presenting with an injury should not be presumed to be safe because they are not identified within the CPA system. A thorough assessment is required and teaching on the appropriate use of CPA systems is essential within each DHB's child protection programme.

Part 2: Key issues for a child abuse alert system

A Child Protection Alert system raises ethical, legal and procedural issues.

Stigma

It can be argued that an alert system might do harm by stigmatising families, if the assumption is drawn that the next injury is non-accidental. In this regard, several points are relevant.

1. The prime responsibility of a health professional providing care to a child is the welfare of that child, not the possible stigma to the family created by asking difficult questions.
2. All an alert system does is draw the attention of health professionals to health information that already exists in the clinical record.
3. Any alert system will require training in its proper use, as a part of universal child protection training for DHB clinical staff who work with children. This should reduce any risk that health professionals will jump to conclusions or fail to analyse information in the clinical context.

Privacy

As the representative of the child, parents have the right to know what information is collected on their child and how that is used. Again, several points are relevant.

1. The parents' right, as the child's representative, to know is guaranteed in the Privacy Act 1994. However, this is not absolute.
   - 1.1. Information may be disclosed to other health care providers without consent, or in accordance with the purpose for which information was collected.
   - 1.2. If disclosure to the parents of their child's health information is not in the best interests of the child, the agency is not obliged to disclose it. Points relevant to this issue are as follows:
     - 1.2.1. It is reasonable not to inform parents that an alert has been placed if there is concern that parents may not re-present for medical care of their sick or injured child.

1.2.2. Processes for investigation of child abuse and CYF referral exist in all DHBs. Standard practice is to inform the family where a case has been referred to the statutory authorities, unless this would imperil the safety of the child or the referrer. Therefore, although a family may be unaware that an Alert has been placed, almost always they will be well aware that the DHB has serious care and protection concerns.

2. Within any given DHB, an alert is not adding further information, but pointing to information that has already been collected in order to provide appropriate care

3. Pre-emptive transfer of information to an information store outside the DHB, even if the information is only "Child protection concerns: contact Hawkes Bay DHB", might be regarded as more problematic. However, in this case, the MWS is administered by the Sector Services Group within the Ministry of Health. Sector Services collects and holds information on the MWS to facilitate the provision of significant clinical information to other health care providers. Identifiable information placed on the MWS is not actually disclosed to a health care provider, until the provider asks for it.

4. Security of access to the MWS (see below). DHB patient information systems routinely require both pro-active security measures, and "role-based" access. It is important that these issues are clarified with regard to the MWS, to ensure that only appropriate healthcare providers can access the information.

Establishment of a CPA system and placement of an alert without parental consent have not been tested in a NZ court. Consultation in relation to this has been undertaken. The advice offered was to ensure a robust process to maximise the potential good and minimise the potential for harm through creation of a CPA system and placing of a CPA on a child.

The decision to create a CPA system and place an alert must therefore balance the above legal and ethical concerns against the potential benefit to the child of an alert increasing the likelihood that risks to their safety are detected.

A formal Privacy Impact Assessment has been completed, which reviews the privacy issues in detail. This is available from the National Health Board Business Unit, Ministry of Health; the Paediatric Society of New Zealand or the Violence Intervention Programme.

Procedural Issues:

Siblings

Siblings of an abused child are also at risk[13], and will be listed on the index child's referral to CYF. Placement of alerts on siblings is undertaken as for the index child. While it is always desirable to provide a medical assessment for siblings, this cannot always be resourced. Some DHBs require that siblings receive a medical assessment (thereby ensuring that the DHB is a provider of healthcare to that child), before placing an alert on them.

Security of information

There should be a simple and consistent national agreement regarding who can access alerts, with security similar to that applying to electronic medical record systems in DHB, i.e., access privileges together with a mechanism for routine audit and for identification and management of breaches.

Any alert system which places information on a child on a national system runs a potential risk that people may access the information who have no right to do so. Each source DHB has no control over monitoring, compliance and discipline in other agencies, particularly if private providers seek access to the alert system. However this is a general issue for the entire NHI system, and for all types of alert placed on the MWS, not merely CPA.

The Ministry of Health has a Health Information Strategy and DHBs are working on regional information sharing projects, which will be relevant to this debate.

Removal of alerts

Many children return to the environment in which the abuse occurred, often without the knowledge of statutory authorities or health providers[14]. Because of the complexity of the issues involved and the mobility of these children and their families, it is often not practically possible for a DHB to determine whether or not the risk to the child has been eliminated subsequent to discharge. It is therefore recommended that alerts be left in place until the child turns 17, at which point they are removed. Specific alerts could be removed if requested or otherwise indicated. The decision to remove would be made by the multidisciplinary team (MDT) in the DHB of origin.

Evaluation of effectiveness

As noted above, many studies have shown that child abuse is often missed. There is no evidence in the international scientific literature to prove that a CPA system of the type described here will make a difference. We cannot therefore provide any references to prove that this system will improve identification of child abuse.

There is no evidence, from experience with internal systems over the last decade, that CPA systems cause harm. As with all alert systems, this is merely a common-sense quality assurance procedure, designed to ensure that health care providers know relevant health information. In our view, it is probable that an alert system, as a part of a comprehensive child protection programme, will help improve identification of child abuse, and reduce risk to children. This will be investigated as part of evaluation of the CPA system.

Part 3: The Framework

Child protection alert systems have existed within several District Health Boards (for example, Christchurch and Auckland) for 10 years. Hawkes Bay DHB was the first to place these alerts on the MWS. The ADHB began placing child protection alerts on the MWS on January 1 2009, and has placed hundreds of these Alerts without incident since then. It is intended that the national system will develop incrementally as more DHBs begin to use the MWS for this purpose.

The PSNZ has been working towards integrating these systems into a national Child Protection Alert System since 2004, including a survey of DHBs and extensive consultation with PSNZ members, DHBs (including several DHB legal advisors, and the Chief Operating Officers of DHBNZ), the Privacy Commissioner, the Children's Commissioner, the New Zealand Police and the Ministry of Social Development. The proposal was first publicly presented at the 10th Australasian Congress on Child Abuse and Neglect, Wellington, 2006. In November 2007, the Annual General Meeting of the PSNZ ratified in principle a draft position statement, from which this paper is derived. The proposal has been developed further (see below), and presented again at the PSNZ Annual Scientific Meeting (ASM), Paihia, October 2008 and the Child Protection Satellite Day preceding the PSNZ ASM in Hamilton, November 2009.

This model for implementation is based on the experiences of several DHBs with established systems, including the model developed in Hawke's Bay DHB.

Hawkes Bay District Health Board Child Protection Alert System Model

In 2000, the Children's Commissioner reported on the death of a child in Hawke's Bay due to non-accidental injury, noting poor communication between health professionals and the absence of formal systems to ensure this[11]. A team was formed to address this issue in 2003 including a Community Paediatrician, Child Protection and Family Violence Intervention Programme Coordinators, Quality and Risk Manager, Legal Advisor and the Health Records

Manager. A possible solution was identified that included putting a standard phrase ("Child protection concerns, contact HBDHB") onto the NHI MWS. The proposal was discussed with representatives from the NHI service, facilitated by the Health Records Manager.

In 2004, a meeting was held with the Privacy Commissioner, who agreed in principle to the process. Her advice was that the process required a documented, "robust" system that included a referral to CYF and review by a multidisciplinary team (MDT).

Formal processes since established include a MDT reviewing alerts, policies detailing the process required and documentation templates to record information.

In 2004, HBDHB discussed the use of the MWS with the New Zealand Health Information Services, then custodian of the MWS, and has loaded many alerts successfully since then. No formal complaints have been received. The process is controlled: following agreement by the MDT, the Clinical Director signs the form authorising the alert. This is forwarded to the Health Records Manager who loads the alert onto the NZHIS system, in accordance with the Alerts Policy. Feedback is that the system works. Several DHBs have contacted the HBDHB health record service requesting information.

Key components of the Child Protection Alert system

The legal advisor from each DHB will clearly need to be consulted regarding the development of the CPA System within the DHB. However, consistency of criteria between DHBs is fundamental to the integrity of the system.

Each DHB will need to develop a user-friendly method for clinicians to access an Alert placed on the MWS.

The CPA System, or the lodging of CPA on the MWS, will begin prospectively within each DHB, on a date determined by that DHB. It is not possible to review all historical cases and place alerts. Therefore, children will present where care and protection issues previously have existed, but there will be no alert. Staff receiving training on the alert process should be advised of the prospective nature of the alert application process so that they are not falsely reassured by the absence of an alert.

Key components of the Child Protection Alert system are outlined on the next page.

1. **Criteria**
    a. The child must be formally notified to CYF with care and protection concerns.
    b. A MDT within the DHB agrees that these concerns warrant an Alert
2. **Antenatal Alerts.**
    a. Antenatal alerts can be placed.
    b. The alert is placed on the mother's file, and transfers to the child's file when the baby is born and an NHI number generated.
    c. MDT review occurs prior to discharge from maternity services (6 weeks).
3. **Sibling Alerts.**
    a. Siblings may be included in the notification of the index child.
    b. DHBs may elect to place alerts on siblings with or without a medical assessment, based on consultation with their own MDT and legal advisor.
4. **Procedure**
    a. The Alert is placed electronically with an option to have a paper Alert within files.
    b. The Alert uses the NHI Number
    c. The Alert is also placed on the MWS
    d. Alerts placed on the MWS use the wording: "Child protection concerns, contact *X*DHB", and provide a contact number.
5. **Security**

    There will be a simple and consistent national agreement regarding who can access these alerts, with security similar to that applying to electronic medical record systems in DHBs, i.e., access privileges together with a mechanism for routine audit and for audit of breaches.
6. **Obtaining information from the DHB which originated the Alert**

    Each DHB already has procedures in place to allow access to clinical records, 24 hours a day, 7 days a week. These processes will need to make specific provision for timely access to the detailed clinical information behind CPA.
7. **Removal of the Alert**
    a. Alerts are left in place until the child turns 17, and are then removed. Alerts are removed based on a request made to the Health Records Service in accordance with the DHB Alerts policy. To routinely remove Alerts from those children who have reached the age of 17 requires the DHB to have a procedure that includes regular reviews of Alerts and removal requests being forwarded in accordance with DHB policy.
    b. Specific Alerts may be removed if indicated or requested. Such a decision will be made by the MDT within the DHB which lodged the Alert
8. **Informing parents or caregivers of the Alert**
    a. Routine notification that a CPAS exists risks undermining the purpose of the system. Consequently, it is reasonable to assume that the clinician considering whether or not to inform parents/guardians of the CPA will generally come to the conclusion that it would not be in the best interests of the child
    b. Parents or caregivers will be informed of the Alert if they ask

Governance of the National Child Protection Alert System

Consultation with Senior DHB Managers in Information Technology and the Information Strategy and Architecture Directorate, Ministry of Health confirmed that the MWS is the only practical national option available for sharing Alerts between health providers.

The CPA System is consistent with the function of the MWS. The data dictionary states that *"The Medical Warnings System is a value-added service closely aligned with the National Health Index. It is designed to warn healthcare providers of the presence of any known risk factors that may be important when making clinical decisions about patient care".* [15]

However, the MWS is (technologically) an antiquated system. Because the integrity of data is relatively poorly controlled by the MWS itself (see below), it is vital that all 20 DHBs are bound to a standardised system for the implementation and management of Child Protection Alerts. Anything less will destroy the utility of the CPA system for protecting children from adverse health events.

We have secured agreement from the Chief Operating officers of DHBNZ that no DHB will enter Child Protection Alerts on the NMWS, unless the DHB has established systems supports as specified in the attached guideline (Appendix A). A Memorandum of Agreement has been developed which will be signed between each DHB wishing to implement the system, the National Health Board Business Unit of the Ministry of Health (which holds the information on the NMWS) and the Paediatric Society of New Zealand (which has developed the resource kit to support consistent and effective implementation of the system).

Integrity, access and security of information on MWS

There are a number of issues with the MWS, summarised below.

1. Data Integrity. In other types of Alert already being placed on the MWS, there is no uniformity of data entry. The MWS data dictionary requires that ICD codes be used, but this policy is not adhered to. An enormous variety of phrases are used to describe the same thing (for example, Latex allergy, rubber allergy, allergic to rubber gloves, etc).

   It is of fundamental importance that only one standard phrase is accepted for Child Protection Alerts. As the type of data entered is not tightly controlled by the database itself, it will require rigid quality control of those who enter CPA onto the MWS. We have taken the view that the phrase *"Child protection concerns, contact XDHB"* should always be used. The meaning is clear, it does not divulge sensitive information unnecessarily, and it should be easy to track for audit.

2. Database maintenance. The MWS database was established in the 1960s, and has not been rigorously maintained. For example, the MWS data dictionary was last revised in 2003. It specifies ICD 9 codes, but elsewhere in the health sector the ICD 9 system was replaced by the ICD 10 system some years ago.

3. Access and security of information. For the system to be effective, all health professionals who may care for the child need to be able to access this information, and to do so easily. On the other hand, it should not be visible to those with only peripheral interest in the child. It is not clear exactly who has access to the MWS at present. Although there are different levels of access for different types of healthcare provider (hospitals, community pharmacists etc), who has access varies from region to region across the country, and levels of access vary according to which software is used by the organisation. DHBs wishing to use the MWS for child protection alerts need a better understanding of the access agreements between providers and NMWS.

Progression of the Child Protection Alert System

A working party was first established in 2008, under the auspices of the PSNZ, to examine the feasibility of a national CPA System. The working group included paediatricians, Child Protection Co-ordinators and the National Violence Intervention Programme Manager.

The working group's purpose was to consider key stakeholder issues, such as community consultation, access and security of information and monitoring. The group noted issues that needed further clarification (including information technology issues), and that any implementation of the CPA System would be undertaken with a systems approach to support change. This systems approach would include policies, training materials, resources and an evaluation process. An interim report was first produced in April 2008, distributed to the PSNZ Child Protection Special Interest Group (CPSIG) and the Family Violence Intervention Programme Co-ordinators in all 20 DHB, and discussed at several national meetings.

Dr Denise Wilson, Associate Professor Maori Health, School of Public Health & Psychosocial Studies Faculty of Health & Environmental Sciences at Auckland University of Technology (AUT) has agreed to support the evaluation process.

Progress since then has been as follows:

- Extensive discussions with legal advisors and health information managers from several DHB, Dr Pat Tuohy, Chief Advisor, Child and Youth Health, Ministry of Health, Dr David Galler, Principal Medical Advisor, Ministry of Health and senior staff from the Information Strategy and Architecture Directorate, Ministry of Health
- The proposed system was formally presented to Dr Cindy Kiro, Children's Commissioner, and staff from her Office in May 2008. We were particularly interested in Dr Kiro's views on how wide our community consultation on this proposal should be. Dr Kiro was of the view that wider community consultation was not required. Dr Kiro was strongly supportive of the proposal, and attended the discussion of the proposal at the PSNZ ASM in October 2008 (see below). The proposal has also been discussed with the current Children's Commissioner, John Angus, and has his support.
- The proposal was again presented to the Privacy Commissioner (Marie Shroff) and her staff, including Sebastian Morgan-Lynch (Policy Advisor, Health), in August 2008. The Privacy Commissioner supported the proposal in principle. A formal Privacy Impact Assessment was requested by the Ministry of Health, and was developed collaboratively with Karen Belt, Senior Legal Advisor, Health Information Policy
- Discussions with Police and Child Youth and Family Services. Letters were first sent to Howard Broad, Commissioner of Police, and Ray Smith, Deputy Chief Executive, CYF in June 2008, and positive and supportive responses were received from both. Child Youth and Family have since been fully briefed on progress to date, and in 2009 nominated an Advisor to work with the Paediatric Society on the project.
- Presentations of the proposed system to DHB clinicians in a variety of professional forums, including the College of Emergency Nurses National Conference (August 2008), the PSNZ Child Protection Special Interest Group and the PSNZ ASM (October 2008), the Kids Trauma Conference (May 2009) and the PSNZ ASM CP Satellite Day (November 2009 and November 2010).
- Presentation of the proposal to Hon Tony Ryall, Minister of Health and State Services in February 2009. Minister Ryall has been strongly supportive of the proposal since, and attended the presentation at the Kids Trauma Conference. He has received regular updates on progress since then.
- Letter from the Minister of Health to DHBNZ in September 2009, requesting their engagement in the project. The project was presented to a meeting of the DHBNZ Chief

Operating Officers in May 2010, who supported the development of the system, and agreed to the proposed governance framework.

- Meetings with several officials from the Information Strategy & Architecture Directorate of the Ministry of Health (including their legal advisors), culminating in the completion of a formal Privacy Impact Assessment in September 2010.
- Agreement from the Ministry of Health in October 2010 that the Child Protection Alert system, as proposed, was an appropriate use of the MWS. Followed by agreement to implementation of the system, subject to the agreement of individual DHB to the proposed governance framework.
- Presentation to the Council of the Paediatric Society of New Zealand in October 2010, who have agreed to be a party to the Memorandum of Agreement between the National Health Board Business Unit of the Ministry of Health, and each DHB which chooses to participate in the system.
- Presentation to the Health and Disability Commissioner on November 19, 2010.

Resources for the implementation of a CPA system

A "toolkit" of resources to be used by DHBs establishing a Child Protection Alert system was developed throughout 2009, and finalized in February 2011. The policies and procedures in those DHBs with functioning CPA systems, particularly those DHBs who already lodge CPA on the MWS, were used as the framework for the development of these resources.

These resources include:

- Guideline for development of Child Protection Alerts System (Appendix A)
- CPA policy, which includes criteria for alert placement, process for application and removal (as indicated) and health record response to request for information
- Terms of Reference for Multidisciplinary Team
- Standardised documentation forms
- CPA System training slides
- Flowchart of response for staff to guide their response to CPA
- Quality improvement activity plan for CPA System.
- Privacy Impact Assessment
- Memorandum of Agreement between the DHB and the Ministry of Health

The documents developed are clinically focussed and provide clear guidelines. For example, if there was a request to access information by a guardian this request would be managed according to the policy and requirements of the Official Information Act, which requires that the originator of data must be consulted before information is released.

Progressive implementation of the national CPA system in DHBs

The proposed national CPA system will only reach its full potential when all 20 DHBs participate. However, the quality of the system is the first priority.

At present, only two DHB (Auckland and Hawkes Bay) are placing Child Protection Alerts on the MWS in a manner compliant with the standards that have been developed. The other 18 DHB can already access those Alerts.

It is intended that other DHBs, once they have established systems supports as specified in the attached guideline (Appendix A), and "opt in" to the National CPA system, will begin to lodge CPA on the MWS. It is hoped that at least 6 further DHBs will opt in to the system

within the next 12 months. It may well take several years before all 20 DHBs are participating fully in the system.

Summary

A nationally consistent Child Protection Alert System is achievable and would enhance information sharing between DHBs. The system has national and local level support and its implementation would be consistent with national recommendations regarding effective child protection intervention. The proposed plan balances competing ethical principles. The outcome of implementing such a system should be enhanced practice and improved child safety.

Contacts

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