Healthcare Improvement Scotland

Healthcare and forensic medical services for people who have experienced rape, sexual assault or child sexual abuse

Indicators

March 2020

NHS SCOTLAND

We are committed to advancing equality, promoting diversity and championing human rights. These standards are intended to enhance improvements in health and social care for everyone, regardless of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation, socio-economic status or any other status. Suggested aspects to consider and recommended practice throughout the standards should be interpreted as being inclusive of everyone living in Scotland.

We carried out an equality impact assessment (EQIA) to help us consider if everyone accessing healthcare and forensic medical services will experience the intended benefits in a fair and equitable way. A copy of the EQIA is published on our website.

Healthcare Improvement Scotland is committed to ensuring that our standards are up to date, fit for purpose, and informed by quality evidence and best practice. We consistently assess the validity of our standards documents, working with stakeholders across health and social care, the third sector and those with lived experience. We encourage you to contact the standards and indicators team at hcis.standardsandindicators@nhs.net to notify us of any updates that the indicator project team may need to consider.

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Introduction

In 2017, Healthcare Improvement Scotland (HIS) developed standards to ensure consistency in approach to healthcare and forensic medical services for anyone who has experienced rape, sexual assault or child sexual abuse[1]. The standards set the same high level of care for everyone, regardless of geographical location, an individual's personal circumstances, or age. The standards support the Scottish Government's vision for the delivery of health and social care services as set out in the Health and Social Care Delivery Plan[2].

The standards are intended to:

- support a multi-professional, multi-agency and coordinated response
- to promote optimal care, and
- outline how services can minimise any additional trauma.

Standardising quality of care further enables a consistent approach to the timely collection of high quality evidence which can support any criminal justice proceedings.

The 2017 standards complement existing standards and guidelines including the Child Protection Managed Clinical Networks standards of service provision and quality indicators for the paediatric medical component of child protection services in Scotland[3].

In 2018, the Chief Medical Officer's (CMO's) Taskforce for the Improvement of Services for Victims of Rape and Sexual Assault[4] commissioned HIS to develop a set of indicators to support implementation and monitoring of the 2017 standards. In December 2018, a set of interim indicators were published. Following piloting of these interim indicators, the indicators have been revised. More information about the development of the indicators is set out in Appendix 1. Details of the changes made following the pilot can be found in Appendix 2.

Policy context

The CMO Taskforce's vision, as set out in a five year high level work plan[5], published in October 2017, is 'consistent, person-centred, trauma-informed healthcare and forensic medical services and access to recovery, for anyone who has experienced rape or sexual assault in Scotland'. To underpin this vision, the Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill[6] was introduced to the Scottish Parliament on 26 November 2019.

The Taskforce has six subgroups with responsibility for different elements of delivering the national vision:

- workforce and training
- delivery and performance
- clinical pathways
- quality improvement
- legislation, and
- self-referral.

The CMO Taskforce quality improvement subgroup supports the development of these indicators and two fully defined and consistent datasets for adults and children and young people. The datasets will enable information to be collected for services to demonstrate how they have met these indicators. Together the indicators and datasets will help drive and monitor national improvement in healthcare and forensic medical services.

The indicators will sit alongside three outputs produced by the clinical pathways subgroup:

- the Clinical Pathway for Healthcare Professionals Working to Support Adults who Present Having Experienced Rape or Sexual Assault (Adult Clinical Pathway: March 2020),
- the Clinical Pathway for Children and Young People who have Disclosed Child Sexual Abuse (Children and Young People Clinical Pathway: expected to be published in late 2020), and
- the Sexual Offences Against Adults Examination National Form (known as the 'national form').

The work of the CMO Taskforce sits within the context of wider service improvements. The indicators also take cognisance of the review of the National Child Protection Guidance (2014), and the Scottish Government's exploration of the Barnahus concept[7].

All NHS boards have been asked to commence recording and monitoring of performance data from 1 April 2020. Prior to the development of a national IT solution, a data collection template will allow NHS Boards to collect and submit the required national dataset to Public Health Scotland. Information for the data collection template should be sourced from either a Sexual Offences Against Adults Examination National Form or a Child Protection Paediatric Examination Proforma.

This document contains references or links to legislation that is relevant to forensic medical services. Where relevant, it should be read in conjunction with all legislation referred to, particularly as legislation may have been amended after this document is published.

Scope of the indicators

These indicators have been developed to provide an insight into national performance and improvement in key areas set out the 2017 HIS standards. The indicators apply to all services and organisations, including NHS boards and Integration Joint Boards, who are responsible for the delivery of acute healthcare and forensic medical examinations for people who have experienced rape, sexual assault or child sexual abuse.

Indicators support the implementation of standards as they measure the level of service performance that people received from health and/or social care services within a given reporting period.

Services and organisations can use the indicator framework to gather statistical information for comparison, benchmarking and monitoring. Indicators can only be based on data that are nationally available via existing information systems. Data collection and reporting allows for the identification of areas for improvement in the quality of care for people using the service.

The indicators cover the following areas:

- person-centred and trauma-informed care
- facilities for forensic medical examinations, and
- consistent documentation and data collection.

Services should continue to review their data, as part of internal governance mechanisms, to improve the care and support that they provide. All services are expected to meet the criteria outlined in the 2017 standards regardless of whether a corresponding indicator exists.

Format of the indicators

Each indicator relates to at least one of the criteria in the 2017 standards and includes:

- a rationale providing reasons why the indicator is considered important
- a statement of what is to be measured, and
- details of how the indicator is to be measured.

Terminology

Wherever possible, we have used generic terminology which can be applied across all settings.

The term **person** or **people** is used to refer to the person or people receiving care or support.

The term **child or young person** is used to refer to the person following the child and young person clinical pathway, where a Joint Paediatric Forensic Examination takes place, and information about their examination is recorded in the children and young people dataset.

The term **adult** is used to refer to people following the adult clinical pathway, where a forensic medical examination takes place and information about their examination is recorded in the adult dataset.

Throughout this document, we have used the phrase **sexual offence examiner** (SOE) to refer to the professional carrying out the forensic medical examination.

A **forensic medical examination** is the examination of a victim of a sexual offence which is undertaken within the seven day DNA capture window[8]. Intimate swabs may be taken together with an assessment of any injuries as well as the person's other healthcare and wellbeing needs.

Examinations of children or young people are jointly performed by a paediatrican and a SOE and are known as **Joint Paediatric Forensic Examinations** (JPFEs). Evidence of child sexual abuse, bruising or injuries can be identified outside of the seven day DNA capture window.

Indicator 1: Sex of sexual offence examiner

Rationale

In their research into sexual assault referral centres, Lovett et al and Chowdhury-Hawkins et al noted that all service users expressed a strong preference for female SOEs and they recommended that this should be the norm[9, 10]. Guidance from the Faculty of Forensic and Legal Medicine recommends that people are given the choice of sex of their sexual offence examiner, in line with recommendations from the Royal College of Emergency Medicine[11, 12].

Indicator 1 consists of four measures:

1.1	**Percentage of examinations where a female SOE was available without delay.**
1.2	**Percentage of people given the opportunity to express a preference about the sex of SOE before the start of the examination.**
1.3	**Percentage of people who, having expressed a preference, had this preference met without delay.**
1.4	**Percentage of examinations undertaken by a SOE who is:** **a) female** **b) male, or** **c) not known/not given.**

Relates to criterion 2.10 in the Healthcare Improvement Scotland 2017 standards

How to measure the indicators

Indicator 1.1:	**Percentage of examinations where a female SOE was available without delay.**
Numerator	The number of examinations where the service was able to offer a female SOE.
Denominator	All forensic medical examinations and JPFEs undertaken.
Potential data sources	Service audit based on case reviews and workforce planning data.
Notes	A delayed examination is an examination that is undertaken: • more than three hours from an adult being referred into the service or making contact with the service to request an examination (Indicator 2.1). • more than 12 hours from the time a decision is reached that a JPFE will be necessary at an Interagency Referral Discussion for children and young people (Indicator 2.2). The reason for delay of examination should be recorded for all examinations outside the timelines, as per Indicator 2.

	'Examiner' refers to the SOE. In a JPFE, the SOE is the examiner who provides the forensic expertise for the examination.
Indicator 1.2:	**Percentage of people given the opportunity to express a preference about the sex of SOE before the start of the examination.**
Numerator	The number of people who were asked before the start of the examination if they had a preference of sex of SOE.
Denominator	All forensic medical examinations and JPFEs undertaken.
Potential data sources	National adult and children and young people's datasets – information sourced from either the Sexual Offences Against Adults Examination National Form or the Child Protection Examination Proforma.
Exclusions	Where a person's age or cognitive ability prevents them from expressing a preference even with appropriate support.
Note:	'Examiner' refers to the SOE. In a JPFE, the SOE is the examiner who provides the forensic expertise for the examination.
Indicator 1.3:	**Percentage of people who, having expressed a preference, had this preference met without delay.**
Numerator	The number of forensic medical examinations undertaken, including JPFEs, where the SOE met the person's preference of sex and the examination was not delayed due to unavailability of the preferred sex of SOE.
Denominator	All forensic medical examinations and JPFEs undertaken where a person expressed a preference of sex of SOE.
Potential data sources	National adult and children and young people's datasets – information sourced from either the Sexual Offences Against Adults Examination National Form or the Child Protection Examination Proforma.
Exclusions	Where the delay to the examination was due to other factors such as unavailability of an appropriate facility or unavailability of equipment.
Note:	A delayed examination is an examination that is undertaken: • more than three hours from an adult being referred into the service or making contact with the service to request an examination (Indicator 2.1). • more than 12 hours from the time a decision is reached that a JPFE will be necessary at an Interagency Referral

	Discussion (IRD) for children and young people (Indicator 2.2). The reason for delay of examination should be recorded for all examinations outside the timelines as per Indicator 2. 'Examiner' refers to the SOE. In a JPFE, the SOE is the examiner who provides the forensic expertise for the examination.
Indicator 1.4:	**Percentage of examinations undertaken by a SOE who is:** **a) female** **b) male, or** **c) not known/not given.**
Numerator	The number of forensic medical examinations and JPFEs undertaken, where the SOE was: • female • male, or • not known/not given.
Denominator	All forensic medical examinations and JPFEs undertaken.
Potential data sources	National adult and children and young people's datasets – information sourced from either the Sexual Offences Against Adults Examination National Form or the Child Protection Examination Proforma.
Notes	'Examiner' refers to the SOE. In a JPFE, the SOE is the examiner who provides the forensic expertise for the examination.

Indicator 2: Timing of forensic medical examination

Rationale

The timing of the forensic medical examination should be person-centred and trauma-informed. Forensic medical examinations and JPFEs should be planned appropriately following discussions with the person, the SOE, and others as appropriate, for example, a paediatrician. The principles of trauma-informed care should be applied throughout the process of a person's care. This will enable the person to have as much sense of choice and collaboration about the examination and their subsequent care as possible, enhancing their sense of safety and trust[9].

A forensic medical examination should commence within three hours[13] of the person being referred to or contacting the service to request a forensic medical examination[1].

An IRD which includes a paediatrician should be convened in cases of child sexual abuse. JPFEs following an IRD within the 7 day DNA capture window should commence within 12 hours[3] of the referral being received. Examinations between 10pm and 8am should be avoided for children and young people unless there is an urgent need[14].

Indicator 2 consists of two measures:

2.1	**Percentage of forensic medical examinations which commenced within three hours of the person being referred into the service or making contact with the service to request an examination.**
2.2	**Percentage of JPFEs which commenced within 12 hours of the person being referred to a JPFE.**

Relates to criteria 2.11 and 2.12 in the Healthcare Improvement Scotland 2017 standards

How to measure the indicators

Indicator 2.1:	**Percentage of forensic medical examinations which commenced within three hours of the person being referred into the service or making contact with the service to request an examination.**
Numerator	The number of forensic medical examinations where the time between a person being referred into the service or making contact with the service to request an examination to the time the examination starts was less than three hours.
Denominator	All forensic medical examinations undertaken which were not delayed due to choice, medical necessity or temporarily diminished capacity.
Potential data sources	National adult datasets – information sourced from the Sexual Offences Against Adults Examination National Form.
Exclusions	Where: • a person or their legally appointed proxy chooses to delay the examination • a person requires emergency medical treatment, or • a person is intoxicated, unconscious, or otherwise temporarily unable to consent.
Notes:	Referral into a forensic medical service is the initial contact between a person or their legally appointed proxy (in cases of self-referral), or police (in cases of police referrals), and the forensic medical service, after a person has expressed a wish for this referral. The term police is a reference to Police Scotland, the British Transport Police or any other police force that has jurisdiction to investigate the crime. The exclusion criterion, *where a person chooses to delay the examination*, may include where a person or their legally appointed proxy: • stops the examination process at any point • expresses uncertainty at the point of referral, or • chooses to discuss their options further. The time of referral or report to the police is recorded on the Sexual Offences Against Adults Examination National Form to give an indication of the overall waiting time between initial referral to the police and the commencement of a forensic medical examination.

	Where the indicator is not met, services should record the reasons for the delay on the national dataset. Services will be expected to consider the reasons for delay as part of wider self-evaluation.
Indicator 2.2:	**Percentage of JPFEs which commenced within 12 hours of the person being referred to a JPFE.**
Numerator	The number of JPFEs where the time between referral from IRD and the time the examination starts was less than 12 hours.
Denominator	All JPFEs undertaken.
Potential data sources	National children and young people's datasets – information sourced from the Child Protection Examination Proforma.
Exclusions	Where: • the last reported incident occurred more than seven days before the start date of the IRD • it is not in the best interests of the child for the examination to take place within 2 hours of the IRD • a young person with capacity to consent requests a delay, or • a child does not have capacity and a parent or person with legal guardianship responsibility requests a delay.

Indicator 3: Examination support

Rationale

People who undergo a forensic medical examination following a rape or sexual assault should always be examined by a SOE with another healthcare professional present. This is in line with General Medical Council (GMC) guidance that everyone should be offered a chaperone for intimate examinations[15].

The accompanying healthcare professional should be:

- familiar with the examination procedure being carried out
- sensitive and respect the individual's dignity and confidentiality
- present throughout the entirety of the examination
- positioned so they have a clear view of what the clinician is doing, as well as being able to clearly hear everything the clinician is saying
- present to reassure the person being examined if they show signs of distress or discomfort, and
- prepared to raise concerns if they are concerned about the clinician's behaviour or actions[15, 16].

A forensically trained nurse can provide trauma-informed support and reassurance to the person during the examination; cover the GMC requirement for a chaperone; and may also act as a corroborating witness in accordance with the requirements of the Scottish criminal justice system. A healthcare professional acting as a chaperone, who is not forensically trained, should only be used to corroborate the examination if no other forensically trained healthcare professional is available.

During a JPFE, each examiner may act as the chaperone and corroborating witness for the other.

Indicator 3 consists of two measures:

3.1	**Percentage of people who were supported by a forensically trained nurse throughout their forensic medical examination.**
3.2	**Percentage of people who were supported by another appropriate healthcare professional throughout their forensic medical examination.**

Relates to criterion 2.13 in the Healthcare Improvement Scotland 2017 standards

How to measure the indicators

Indicator 3.1:	**Percentage of people who were supported by a forensically trained nurse throughout their forensic medical examination.**
Numerator	The number of forensic medical examinations where the additional appropriate healthcare professional in the forensic medical examination was a forensically trained nurse.
Denominator	All forensic medical examinations undertaken.
Potential data sources	National adult dataset – information sourced from the Sexual Offences Against Adults Examination National Form.
Exclusions	JPFEs.
Note:	A forensically trained nurse is a nurse who has completed relevant sexual offence examination training which covers corroboration and providing trauma-informed support. This person must be in addition to the SOE.
Indicator 3.2:	**Percentage of people who were supported by another appropriate healthcare professional throughout their forensic medical examination.**
Numerator	The number of forensic medical examinations where the person was supported by another appropriate healthcare professional in addition to the SOE throughout the examination.
Denominator	All forensic medical examinations where there was an additional healthcare professional present throughout the examination.
Potential data sources	National adult dataset – information sourced from the Sexual Offences Against Adults Examination National Form.
Exclusions	JPFEs.
Notes:	A healthcare professional must meet the GMC guidelines as outlined in the rationale in order to meet the requirements of being an ‘appropriate’ healthcare professional.

Indicator 4: Assessed support needs and ongoing safety planning

Rationale

People who have experienced rape, sexual assault or child sexual abuse may be at higher risk for suicide and self-harm[17] and should be assessed for immediate safety, suicidality, and social support. Psychological First Aid is preferred to psychological debriefing in the immediate period after a person has experienced trauma[18]. People who have experienced rape, sexual assault or child sexual abuse may be at risk of other forms of domestic, gender-based and/or intimate partner violence[19, 20] and should be screened and referred to services accordingly. Assessments should be made as part of a trauma-informed and collaborative discussion. This may help a person to regain a sense of control over their environment and ongoing recovery[17, 21].

A comprehensive needs assessment should include assessment of additional support needs due to disability or existing vulnerability, cultural or language barriers, existing or ongoing safety planning, housing needs, social work referrals, legal and advocacy services, and immediate crisis services. All agencies should adhere to existing guidance on safeguarding and to local public protection procedures.

A comprehensive social, emotional and wellbeing support assessment should be made, in line with Royal College of Paediatrics and Child Health guidelines and Faculty of Forensic and Legal Medicine guidelines[3, 22].

A person must be given opportunities to fully understand the process of the examination and any implications[23]. The purpose of a forensic medical examination should be explained to the person in a way and at a pace that they can understand. Sufficient time should be provided to consider the decision they are making.

Immediate follow-up in the aftermath of rape, sexual assault and child sexual abuse may reduce the long-term effects of trauma[24, 25]. Support should be given to the person and, in the case of children and young people, their primary carers[25]. Follow up appointments should be organised by the service and support should be available to facilitate attendance at follow up appointments.

Indicator 4 consists of four measures:

4.1	**Percentage of people who received a psychosocial risk assessment at the time of the examination.**
4.2	**Percentage of people who were referred to all required services identified during a psychosocial risk assessment.**
4.3	**Percentage of people who were referred to:** **a) sexual health services** **b) a relevant third sector support organisation** **c) mental health services, or** **d) their GP.**
4.4	**Percentage of cases where initial follow-up contact was made by the forensic medical service within 72 hours of the end of the examination.**

Relates to criteria 1.1, 1.3 and 2.6 in the Healthcare Improvement Scotland 2017 standards

How to measure the indicators

Indicator 4.1:	**Percentage of people who received a psychosocial risk assessment at the time of the examination.**
Numerator	The number of people who received a psychosocial risk assessment at the time of the forensic medical examination, JPFE or healthcare assessment.
Denominator	All people who underwent a forensic medical examination, JPFE or healthcare assessment within a forensic medical service.
Potential data sources	• National adult and children and young people's datasets – information sourced from either the Sexual Offences Against Adults Examination National Form or the Child Protection Examination Proforma. • Case review audits. • IRD notes review.
Notes:	'Examination' refers to the forensic medical examination, JPFE or healthcare assessment. The psychosocial risk assessment should be trauma-informed to ensure questions are asked sensitively and without judgement[26]. To meet the indicator, relevant questions relating to wellbeing, risk, safety on leaving examination and action planning must be completed in full, and where no risk is identified, this should be recorded.

	A comprehensive psychosocial risk assessment for adults includes all questions in the Sexual Offences Against Adults Examination National Form and Children and Young Person's Proforma, including screening questions as part of: • safe lives checklist • domestic abuse screening questions • questions relating to drug and alcohol usage • questions relating to self-harm • questions relating to history of suicide • relationship to perpetrator (i.e. if they live with them) • housing circumstances • child protection risk assessment, and • adult support and protection risk assessment. For children and young people, an immediate risk assessment may be performed by other relevant agencies as part of ongoing child protection protocols.
Indicator 4.2:	**Percentage of people who were referred to all required services identified during a psychosocial risk assessment.**
Numerator	The number of people who were referred to all of the services identified as being required during a psychosocial assessment.
Denominator	All people who underwent a forensic medical examination, JPFE or healthcare assessment within a forensic medical service and received a psychosocial risk assessment.
Potential data sources	National adult and children and young people's datasets – information sourced from either the Sexual Offences Against Adults Examination National Form or the Child Protection Examination Proforma.
Exclusions	Where: • a person or their legally appointed proxy chooses not to be referred (in situations where there is no legal duty to make the referral), or • a person is already attending the service to which they have been referred.
Notes:	People who have experienced rape or sexual assault should have their ongoing support and safety planning coordinated by an appropriately trained person within the forensic medical service. Referrals must be made in consultation with the individual and with their full knowledge and involvement.

	If, in exceptional circumstances, a referral is made to a statutory agency without the person's consent, the person should be supported to understand the reasons behind this decision. The indicator is met if there is a complete match between the person's support needs as identified and the referrals made by the forensic medical service. To satisfy the dataset, the questions relating to wellbeing, risk assessment, safety on leaving examination and action planning must be completed. Where another service cannot accept the referral, or the referral is not appropriate, this should be explored and recorded.
Indicator 4.3:	**Percentage of people who were referred to:** **a) sexual health services** **b) a relevant third sector support organisation** **c) mental health services, or** **d) their GP.**
Numerator	The number of people who were referred by the forensic medical service to each listed service.
Denominator	All people who underwent a forensic medical examination, JPFE or healthcare assessment within a forensic medical service and were identified as requiring onward referral.
Potential data sources	National adult and children and young people's datasets – information sourced from either the Sexual Offences Against Adults Examination National Form or the Child Protection Examination Proforma.
Exclusions	Where: • a person or their legally appointed proxy chooses not to be referred, or • a person is already attending the service to which they have been referred.

Note:	A relevant third sector support organisation is an organisation which provides specialist support, counselling, or advocacy for people who have experienced rape, sexual assault, or child sexual abuse. This includes, but is not limited to: • Rape Crisis Scotland • NSPCC • Children 1st • Victim Support Scotland • Scottish Women's Aid • Survivors UK
Indicator 4.4:	**Percentage of cases where initial follow-up contact was made by the forensic medical service within 72 hours of the end of the examination.**
Numerator	The number of cases where initial follow-up contact was made by the forensic medical service within 72 hours of the end of the forensic medical examination, JPFE or healthcare assessment.
Denominator	All people who underwent a forensic medical examination, JPFE or healthcare assessment within a forensic medical service and provided contact details.
Potential data sources	Service audit.
Exclusions	Where: • a person or their legally appointed proxy does not consent to further contact, or • a person requests contact outside the time frame.
Note:	'Examination' refers to the forensic medical examination, JPFE or healthcare assessment. Contact can be made by a nurse coordinator, advocacy or support worker. Timing and contact details should be discussed at the time of examination.

Indicator 5: Access to immediate sexual health care

Rationale

The risk for pregnancy after rape is approximately 7%, with adolescents identified as being most at risk[27, 28]. Emergency contraception should be provided, where required[11].

The frequency and type of sexually transmitted infections acquired from sexual assault depends on local prevalence and the nature of the assault[29]. People who have experienced rape or sexual assault may be at risk of hepatitis B virus infection[30]. Hepatitis B vaccine is highly effective at preventing infection if given shortly after exposure and should be offered to all who may have been at risk[31].

Although the risk of HIV infection from a sexual assault or rape appears to be low[32, 33], it may be a concern for people who have experienced rape or sexual assault. Post-exposure prophylaxis for HIV should be given within 72 hours of an assault[34].

Indicator 5 consists of three measures:

5.1	**Percentage of people who received emergency contraception at the time of assessment.**
5.2	**Percentage of people who commenced post-exposure prophylaxis for hepatitis B at the time of assessment.**
5.3	**Percentage of people who commenced post-exposure prophylaxis for HIV at the time of assessment.**

Relates to criteria 1.1, 2.8 and practical examples of evidence of achievement in the Healthcare Improvement Scotland 2017 standards

How to measure the indicators

Indicator 5.1:	**Percentage of people who received emergency contraception at the time of assessment.**
Numerator	The number of people who were given either oral contraception or a copper IUD at the time of assessment.
Denominator	All people who underwent a forensic medical examination, JPFE, or healthcare assessment within a forensic medical service and were identified as requiring emergency contraception.
Potential data sources	National adult and children and young people's datasets – information sourced from either the Sexual Offences Against Adults Examination National Form or the Child Protection Examination Proforma.

Exclusions	Where a person has: • received this from a different service or provider, such as a community pharmacy or A&E • been referred to a different service or provider to receive this at a later time, or • made an informed refusal of emergency contraception.
Indicator 5.2:	**Percentage of people who commenced post-exposure prophylaxis for hepatitis B at the time of assessment.**
Numerator	The number of people who commenced post-exposure prophylaxis treatment for hepatitis B at the time of assessment.
Denominator	All people who underwent a forensic medical examination, JPFE or healthcare assessment within a forensic medical service and were identified as being at risk of hepatitis B, and where the time from exposure to the examination time allows for clinically effective treatment.
Potential data sources	National adult and children and young people's datasets – information sourced from either the Sexual Offences Against Adults Examination National Form or the Child Protection Examination Proforma.
Exclusions	Where a person: • has previously completed a course of vaccination for hepatitis B within the last 12 months • has been referred to a different service or provider to receive this at a later time • is allergic to the medication • cannot consent to medication and consent by a parent or a legally appointed proxy is refused, or • makes an informed choice to decline the medication.
Note:	Prophylaxis should only be given in cases where the risk of transmission is high[31].
Indicator 5.3:	**Percentage of people who commenced post-exposure prophylaxis for HIV at the time of assessment.**
Numerator	The number of people who commenced post-exposure prophylaxis treatment for HIV at the time of assessment.
Denominator	All people who underwent a forensic medical examination, JPFE or healthcare assessment within a forensic medical service and were identified as being at risk of HIV, and where the time from exposure to the examination time allows for clinically effective treatment.

Potential data sources	National adult and children and young people's datasets – information sourced from either the Sexual Offences Against Adults Examination National Form or the Child Protection Examination Proforma.
Exclusions	Where a person: • has a forensic medical examination or health assessment more than 72 hours after possible exposure and is therefore outside the clinical window for effective prophylaxis • has been referred to a different service or provider to receive this at a later time • is allergic to the medication • cannot consent to medication and consent by a parent or a legally appointed proxy is refused, or • makes an informed choice to decline the medication.
Note:	Prophylaxis should only be given in cases where the risk of transmission is high[34]. Post-exposure prophylaxis for HIV is 3 antiretroviral drugs (in 2 tablets) taken daily for 28 days[34].

Indicator 6: Examination setting

Rationale

Healthcare Improvement Scotland's 2017 healthcare and forensic medical services standards state that all examinations should take place in a health or designated multi-agency setting. Forensic examination facilities for children should be age-appropriate and sensitively designed to reduce trauma[3]. Services must be designed with the person at the centre, with the physical environment and local care pathway having due regard of the impact of trauma, in accordance with the 2017 HIS standards and Scottish Sexual Assault Response Coordination (SSARC) service specification[35].

Indicator 6 consists of one measure:

6.1	**Proportion of examinations that took place in a suitably appointed healthcare or designated multi-agency setting.**

Relates to criterion 3.1a in the Healthcare Improvement Scotland 2017 standards

How to measure the indicators

Indicator 6.1:	**Percentage of examinations that took place in a suitably appointed healthcare or designated multi-agency setting.**
Numerator	The number of forensic medical examinations and JPFEs where the location of examination was a suitably appointed healthcare or designated multi-agency setting.
Denominator	All forensic medical examinations and JPFEs undertaken where the location of the examination was recorded.
Potential data sources	National adult and children and young people's datasets – information sourced from either the Sexual Offences Against Adults Examination National Form or the Child Protection Examination Proforma.
Exclusions	Where an examination was undertaken in: • a social care setting due to frailty or other extenuating circumstances, or • an intensive care, long-term care or hospice setting.

Indicator 7: Facilities decontamination

Rationale

All facilities and equipment for forensic medical examinations should be safe and fit for purpose[36] and must comply with all relevant national standards, specifications and guidelines[3, 12, 35].

In addition to infection prevention and control standards[37], facilities must be decontaminated according to the Scottish Police Authority (SPA) decontamination protocol[38] to maintain stringency of forensic evidence if the case is presented at court.

Indicator 7 consists of one measure:

7.1	**Percentage of forensic medical examinations undertaken in facilities that have been decontaminated in accordance with the SPA national protocol.**

Relates to criterion 3.2 in the Healthcare Improvement Scotland 2017 standards

How to measure the indicators

Indicator 7.1:	**Percentage of forensic medical examinations undertaken in facilities that have been decontaminated in accordance with the SPA national protocol.**
Numerator	The number of examinations undertaken in facilities decontaminated in accordance with the SPA national protocol.
Denominator	All forensic medical examinations and JPFEs undertaken.
Potential data sources	Service audit of SPA decontamination logs supported by environmental monitoring.
Exclusions	Where an examination is undertaken in: • a social care setting, due to frailty or other extenuating circumstances, or • an intensive care, long-term care or hospice setting.

Indicator 8: Colposcopes

Rationale

An up-do-date colposcope should be available for all forensic medical examinations and JPFEs. This equipment should comply with national specifications[35] and be appropriately monitored and maintained by each NHS board.

The magnification and lighting provided by colposcopes may increase the rate of injury detection. Colposcopy allows recording and imaging for peer review purposes and the potential to be used to facilitate further expert medical opinion.

Indicator 8 consists of one measure:

8.1	**Percentage of forensic medical examinations which used a colposcope**

Relates to criterion 3.3 in the Healthcare Improvement Scotland 2017 standards

How to measure the indicators

Indicator 8.1:	**Percentage of forensic medical examinations which used a colposcope**
Numerator	The number of forensic medical examinations and JPFEs where a colposcope was used
Denominator	All forensic medical examinations and JPFEs undertaken, where a colposcope was identified as being required.
Potential data sources	Service audit based on case reviews.
Exclusions	Cases where • a person or their legally appointed proxy did not consent to the use of a colposcope • a colposcope was not required
Note	All colposcopes must comply with national specifications.

Indicator 9: National forensic medical examination documentation

Rationale

The use of standardised documentation, electronic or paper, will ensure a consistent national approach and minimise unwarranted variation. The Sexual Offences against Adults National Form aims to provide consistency of reporting across Scotland and should always be used to minimise variation. The Child Protection Paediatric Examination Proforma should always be used to enable consistency in reporting.

Indicator 9 consists of three measures:

9.1	**Percentage of forensic medical examinations where both parts of the Sexual Offences against Adults National Form were appropriately completed within 24 hours of the end of the examination.**
9.2	**Percentage of JPFEs where all relevant sections of the Child Protection Paediatric Proforma were appropriately completed within 24 hours of the end of the examination.**
9.3	**Percentage of JPFEs where an agreed summary of findings report was completed within 28 days of the end of the examination.**

Relates to criterion 5.3 in the Healthcare Improvement Scotland 2017 standards

How to measure the indicators

Indicator 9.1:	**Percentage of forensic medical examinations where both parts of the Sexual Offences against Adults National Form were appropriately completed within 24 hours of the end of the examination.**
Numerator	The number of forensic medical examinations where both parts of the Sexual Offences against Adults National Form were appropriately completed within 24 hours of the end of the examination.
Denominator	All forensic medical examinations undertaken.
Potential data sources	Service audit based on case review.
Notes	The national form will be considered ‘completed’ where all relevant sections of each part of the form contain appropriate information and the formal summary of findings is completed according to all reporting guidance. To be ‘appropriately completed’ the information must be: • legible • valid • accurate, and • sufficient.

Indicator 9.2:	**Percentage of JPFEs where all relevant sections of the Child Protection Paediatric Proforma were appropriately completed within 24 hours of the end of the examination.**
Numerator	The number of JPFEs where all relevant sections of the Child Protection Paediatric Proforma were appropriately completed within 24 hours of the end of the examination.
Denominator	All JPFEs undertaken.
Potential data sources	Service audit based on case review.
Notes	All relevant sections of the profroma must contain information for the form to be 'completed'. To be 'appropriately completed' the information contained in the form must be: • legible • valid • accurate, and • sufficient.
Indicator 9.3:	**Percentage of JPFEs where an agreed summary of findings report was completed within 28 days of the end of the examination.**
Numerator	The number of JPFEs where an agreed summary of findings report was completed within 28 days of the end of the examination.
Denominator	All JPFEs undertaken.
Potential data sources	Service audit based on case review.
Note:	'Completed' refers to the inclusion of all relevant information which is required for judicial proceedings. 'Agreed', refers to agreement of the contents of the report between the examining paediatrician and SOE.

References

1. Healthcare Improvement Scotland. Health and Forensic Medical Services for People who have experienced Rape, Sexual Assault or Child Sexual Abuse: Children, Young People and Adults Standards 2017 [cited 20 Feb 2020]; Available from: http://www.healthcareimprovementscotland.org/our_work/person-centred_care/resources/sexual_assault_services.aspx.
2. Scottish Government. Health and Social Care Delivery Plan 2016 [cited 20 Feb 2020]; Available from: http://www.gov.scot/Resource/0051/00511950.pdf.
3. NHS Scotland. Standards of Service Provision and Quality Indicators for the Paediatric Medical Component of Child Protection Services in Scotland 2017 [cited 20 Feb 2020]; Available from: http://www.mcncsa.scot.nhs.uk/wp-content-uploads-Standards-QIs_for_Child_Protection_Medical_Examinations_v1.pdf
4. Scottish Government. Rape and Sexual Assault Victims Taskforce 2017 [cited 20 Feb 2020]; Available from: https://beta.gov.scot/groups/taskforce-to-improve-services-for-rape-and-sexual-assault-victims/.
5. Scottish Government. Rape and Sexual Assault Victims Taskforce Work Plan 2017 [cited 20 Feb 2020]; Available from: https:beta.gov.scot/publications/rape-and-sexual-assault-victims-taskforce-high-level-work-plan
6. Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill Scottish Parlaiment,(2019).
7. Healthcare Improvement Scotland. Our Work: Barnahus Standards [cited 10 February 2020]; Available from: http://www.healthcareimprovementscotland.org/our_work/standards_and_guidelines/stnds/barnahus_standards.aspx.
8. Scottish Parliamant. Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill Policy Memorandum 2019 [cited 10 February 2020]; Available from: https://www.parliament.scot/parliamentarybusiness/Bills/113572.aspx.
9. Lovett J, Regan L, Kelly L. Sexual assault referral centres: developing good practice and maximising potentials. 2004 [cited 20 Feb 2020]; Available from: http://library.college.police.uk/docs/hors/hors285.pdf.
10. Chowdhury-Hawkins R, McLean I, Winterholler M, Welch J. Preferred choice of gender of staff providing care to victims of sexual assault in Sexual Assault Referral Centres (SARCs). Journal of forensic and legal medicine. 2008;15(6):363-7. Epub 2008/07/01.
11. Royal College of Emergency Medicine. Management of Adult Patients who attend Emergency Department after Sexual Assault and/or rape 2015 [cited 20 Feb 2020]; Available from: https://www.rcem.ac.uk/docs/College%20Guidelines/5s.%20Management%20of%20Adult%20Patients%20who%20attend%20Emergency%20Departments%20after%20Sexual%20Assault%20and%20or%20Rape%20(revised%20Oct%202015).pdf.
12. Faculty of Forensic and Legal Medicine. Quality Standards in Forensic Medicine, General Forensic Medicine (GFM) and Sexual Offence Medicine (SOM) 2016 [cited 20 Feb 2020].
13. National Sexual Assault Response Team (SART) Guidelines Development Group. National Guidelines on Referral and Forensic Clinical Examination Following Rape and and Sexual Assault (Ireland) 4th edition 2018 [cited 20 Feb 2020]; Available from: https://www.hse.ie/eng/services/publications/healthprotection/sart-national-guidelines-4th-edition.pdf.
14. Faculty of Forensic and Legal Medicine, Royal College of Paediatrics and Child Health (RCPCH). Sexual Offences: Pre-Pubertal Complains 2016.

15. General Medical Council. Intimate examinations and chaperones 2013 [cited 20 Feb 2020]; Available from: http://www.gmc-uk.org/guidance/ethical_guidance/21168.asp.
16. Royal College of Emergency Medicine. Best practice Guideline: Chaperones in Emergency Departments 2015 [cited 20 Feb 2020]; Available from: https://www.rcem.ac.uk/docs/College%20Guidelines/5v.%20Chaperones%20in%20the%20Emergency%20Department%20(March%202015).pdf.
17. Decker SE, Naugle AE. Immediate Intervention for Sexual Assault: A Review with Recommendations and Implications for Practitioners. Journal of Aggression, Maltreatment & Trauma. 2009;18(4):419-41.
18. (NICE) NIfHaCE. Post-traumatic stress disorder: management, Clinical Guideline CG26. 2005 [cited 20 Feb 2020]; Available from: https://www.nice.org.uk/guidance/cg26.
19. Scottish Government. Equally Safe: Scotland's strategy to eradicate violence against women and girls 2018 [cited 14 Nov 2018]; Available from: https://www.gov.scot/publications/equally-safe-scotlands-strategy-prevent-eradicate-violence-against-women-girls/.
20. Finneran C, Stephenson R. Intimate Partner Violence among Men Who Have Sex with Men: A Systematic Review. Trauma, violence & abuse. 2013;14(2):168-85.
21. Alpert EJ. A just outcome, or 'just' an outcome? Towards trauma-informed and survivor-focused emergency responses to sexual assault. Emergency Medicine Journal. 2018.
22. Faculty of Forensic and Legal Medicine, Royal College of Paedriatrics and Child Health. Guidelines on Paedriatric Forensic Examinations in Relation to Possible Child Sexual Abuse 2012 [cited 20 Feb 2020]; Available from: https://fflm.ac.uk/wp-content/uploads/documentstore/1352802061.pdf.
23. Olsen A. Improving service responses for people with learning disabilities who have been sexually assaulted: An audit of forensic services. British Journal of Learning Disabilities. 2017;45(4):238-46.
24. Directorate-General for Internal Policies, Citizens' Rights and Constitutional Affairs, Policy Department. Overview of the worldwide best practices for rape prevention and for assisting women victims of rape 2013 [cited 20 Feb 2020]; Available from: http://www.europarl.europa.eu/regdata/etudes/etudes/join/2013/493025/IPOL-FEMM_ET(2013)493025_EN.pdf.
25. Galloway S, Love R, Wales A, NSPCC. The Right to Recover: Therapeutic services for children & young people following sexual abuse, an overview of provision in the West of Scotland 2017 [cited; Available from: https://learning.nspcc.org.uk/media/1128/right-to-recover-sexual-abuse-west-scotland.pdf.
26. NHS National Education for Scotland, Scottish Government. The Scottish Psychological Trauma Training Plan 2019 [cited 20 Feb 2020]; Available from: https://www.nes.scot.nhs.uk/media/4321706/Scottish%20Psychological%20Trauma%20Training%20Plan%202019.pdf.
27. Coleman G. Pregnancy after rape International Journal of Women's Health and Wellness 2015;1(1):1-4.
28. Welch J, Mason F. Rape and sexual assault. BMJ. 2007;334(7604):1154-8.
29. Sachs CJ, Thomas B. Sexual Assault, Infectious Disease Prophylaxis [internet]: StatPearls; 2018.
30. Seña AC, Hsu KK, Kellogg N, Girardet R, Christian CW, Linden J*, et al.* Sexual Assault and Sexually Transmitted Infections in Adults, Adolescents, and Children. Clinical Infectious Diseases. 2015;61(suppl_8):S856-S64.
31. British Association for Sexual Health (BASSH). United Kingdom National Guidelines on the Management of the Viral Hepatitides A, B, and C 2015 [cited 20 Feb

2020]; Available from: https://www.bashhguidelines.org/media/1066/uk-bashh-hepatitis-guidelines-2015.pdf.
32. US Department of Justice, Women OoVA. A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents 2013 [cited 20 Feb 2020]; Available from: https://www.ncjrs.gov/pdffiles1/ovw/241903.pdf.
33. Draughon JE, Hauda WE, Price B, Rotolo S, Austin KW, Sheridan DJ. Factors Associated With Forensic Nurses Offering HIV nPEP Status Post Sexual Assault. Western Journal of Nursing Research. 2015;37(9):1194-213.
34. British Association for Sexual Health (BASSH). UK Guideline for the use of HIV Post-Exposure Prophylaxis Following Sexual Exposure 2015 [cited 20 Feb 2020]; Available from: https://www.bashhguidelines.org/media/1027/pepse-2015.pdf.
35. NHS Scotland, Scottish Government, Police Scotland, Rape Crisis Scotland, Scottish Police Authoirty. Scottish Sexual Assault Response Coordination (SSARC) Health Board Service Specification. 2019 [cited 07 Jan 2020]; Available from: https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2019/12/rape-sexual-abuse-or-child-sexual-abuse-medical-services-guide-for-service-providers/documents/rape-sexual-abuse-or-child-sexual-abuse-medical-services-guide-for-service-providers/rape-sexual-abuse-or-child-sexual-abuse-medical-services-guide-for-service-providers/govscot%3Adocument/Health%2BBoard%2BService%2BSpecification%2BSSARC%2BDec2019.pdf.
36. Scottish Government. The healthcare quality strategy for NHSScotland [online]. 2010 [cited 20 Feb 2020]; Available from: http://www.gov.scot/Publications/2010/05/10102307/4.
37. Health Protection Scotland. National Infection Prevention and Control Manual 2014 [cited 20 Feb 2020]; Available from: http://www.nipcm.scot.nhs.uk/.
38. Scottish Police Authority Forensic Services. DNA Decontamination Guidelines for Forensic Medical Examinations 2019 [cited 20 Feb 2020]; Available from: https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2019/10/forensic-medical-examinations-dna-decontamination-guidelines/documents/forensic-medical-examinations-dna-decontamination-protocol/forensic-medical-examinations-dna-decontamination-protocol/govscot%3Adocument/FS-BIO-0180%2B-%2BDNA%2Bdecontamination%2Bprotocol%2Bfor%2Bforensic%2Bmedical%2Bexaminations.pdf.

Appendix 1: Development of the indicators

The Indicators for Healthcare and Forensic Medical Services for People who Have Experienced Rape, Sexual Assault or Child Sexual Abuse: Children, Young People and Adults have been informed by the 2017 healthcare and forensic medical services standards, current evidence and best practice recommendations, and developed by group consensus. Interim indicators were published in 2018, and have been subject to pilot and review.

Development activities

An indicators development group was convened in July 2018 to consider the evidence and to help identify key themes for indicator development. Dr Cliff Sharp, Medical Director, NHS Borders is the development group chair.

The development group consisting of clinical, governmental and third sector experts reviewed the 2017 standards and identified 10 key indicators of high quality care and support which were grouped under the following themes:

- person-centred and trauma-informed care
- facilities for forensic medical examinations, and
- consistent documentation and data collection.

Membership of the development group is set out in Appendix 3.

To ensure each indicator is underpinned with the views and expectations of both health and social care staff, third sector representatives, people and the public in relation to healthcare and forensic medical services, information has been gathered from a number of sources and activities, including:

- literature review
- pilot review of the interim indicators
- sharing intelligence with Taskforce subgroups and data colleagues, and
- development group meetings.

Piloting the interim indicators

Healthcare Improvement Scotland published the interim indicators in December 2018. The indicators were piloted alongside the national dataset for adults in July 2019 and the national dataset for children and young people between January and October 2019. The indicators were piloted to ensure that they provide meaningful data to support improvements in the care and support of all people who have experienced rape, sexual assault and child sexual abuse.

The results of the pilot have been discussed by the development group and a range of stakeholders. Changes to the interim indicators are outlined in Appendix 2.

Quality assurance

All development group members were responsible for advising on the professional aspects of the indicators. Clinical members of the development group were also responsible for advising on clinical aspects of the work. The chair was assigned lead responsibility for providing formal clinical assurance and sign-off on the technical and professional validity and acceptability of any reports or recommendations from the group.

All development group members were asked to declare any interests at the beginning stages of the project. They also reviewed and agreed to the group's Terms of Reference. More details are available on request from hcis.standardsandindicators@nhs.net

Healthcare Improvement Scotland also reviewed the indicator document as a final quality assurance check. This ensures that:

- the indicators are developed according to agreed Healthcare Improvement Scotland methodologies
- the indicator document addresses the areas to be covered within the agreed scope, and
- any risk of bias in the indicator development process as a whole is minimised.

For more information about Healthcare Improvement Scotland's role, direction and priorities, please visit:
www.healthcareimprovementscotland.org/drivingimprovement.aspx

Appendix 2: Changes from the interim indicators

All indicators

Data measurement details, including numerators and denominators, potential data sources, exclusions and notes have been included for all indicators. The phrase 'forensic examiner' has been amended to 'sexual offence examiner'. Following feedback during the consultation process, 'gender', has been changed to 'sex'.

Indicator 1:

An additional indicator, Indicator 1.1, has been added to reflect the timing of when a person is asked about their preference of examiner. An additional indicator 1.3 has been added to measure the availability of a female sexual offence examiner. Additional information has been added to clarify that this indicator also covers the sex of the SOE in JPFEs but does not measure the sex of paediatrician.

Indicator 2:

After feedback from the pilot, 'time of presentation', of children and young people has been clarified as the time a referral is made to a service following an IRD. The indicators have been amended to measure the time from referral into the service to the time of the start of examination, which, for children and young people, measures the time between the referral to JPFE and the start of the examination.

The indicator measuring non-acute JPFE for children and young people has been removed as the indicators have been developed to measure improvements in acute healthcare and forensic medical services in line with the adult and child and young person's clinical pathways.

The timing has been expressed as the number of days, rather than weeks to give a more precise measure.

Indicator 3:

Following feedback from the pilot, the indicator has been clarified to ensure that General Medical Council guidance on intimate examinations is met and that a person is supported throughout the examination.

The term, 'chaperone', has been changed to 'another appropriate healthcare professional', while allowing services the flexibility of meeting the principle of the indicator. An additional indicator, 3.2, reflects the ambition of the service delivery model identified by the Taskforce.

Indicator 4:

Following the pilot, the data notes and reporting guidance have been developed by the indicators development group. For indicator 4.1, the reference to specific risk assessment has been removed as this is explored more fully in the reporting guidance.

Indicator 4.2 has been added to ensure that services are meeting all of the individuals' ongoing support and immediate safety planning needs.

Following further engagement with stakeholders during the pilot the key agencies listed in Indicator 4.3 have been changed.

An additional measure, Indicator 4.4, has been added to reflect the ambition for a nurse co-ordinator role or support and advocacy staff in each NHS Board to provide ongoing follow-up and support.

Indicator 5:

The wording of the indicators has been changed to clarify that post-exposure prophylaxis should be given at the time of examination, with additional notes that this should be within a clinically effective window, and where a person has been identified as being at risk.

Indicator 5.4, relating to pregnancy testing and sexual health follow-up, has been removed due to difficulties with data linkage. Onward referral to sexual health will be recorded as part of Indicator 4.3.

Indicator 6:

Following discussion by the indicator development group, and informed by the pilot, draft Indicator 6 was withdrawn.

Services are requested to consider provision of follow-up mental health services and aftercare as part of the wider system of quality assurance of the standards. Gathering baseline data in this area, including developing mechanisms for data linkage across different services/regions, will inform services of their improvement in this area.

Indicator 7:

To reflect the publication of the Scottish Sexual Offence Response Coordination (SSARC) service specification, the indicator has been amended to measure when examinations take place in a suitably appointed healthcare or multi-agency setting.

Indicator 8:

The indicator has been amended to clarify that decontamination must comply with the Scottish Police Authority national decontamination protocol.

Indicator 9:

Indicator 9.2 was removed to reflect that the updated national specifications for colposcopes includes facilities for digital image storage.

Indicator 10:

The wording of Indicator 10 has been changed to clarify that ‘forensic medical documentation’ refers to the Sexual Offences Against Adults National Form.

The timing has been expressed in days rather than weeks for increased precision. Additional indicators relating to children and young people’s documentation have been added.

Appendix 3: Membership of the indicator development group

Name	Position	Organisation
Cliff Sharp (Chair)	Medical Director	NHS Borders
Sandy Brindley	Chief Executive	Rape Crisis Scotland
Marianne Cochrane	Lead Doctor, Child Protection	NHS Grampian
Hannah Cornish (Interim only)	Programme Manager, Police Care Network	NHS National Services Scotland
Katie Cosgrove	Programme Manager, Gender Based Violence	NHS Health Scotland
Jessica Davidson	Senior Clinical Forensic Charge Nurse	South East Scotland Police Custody Healthcare and Forensic Medical Examination Service
George Fernie	Clinical Advisor, Police Care Network and Forensic Physician	NHS Lothian
Stephanie Govenden	Lead Doctor, Child Protection	North of Scotland Child Protection Managed Clinical Network
Ruth Henry	Manager	Archway Sexual Assault Referral Centre
Anne Marie Hicks (Interim only)	Procurator Fiscal, Sexual Offence Policy	Crown Office
Stuart Houston (Interim only)	National Rape Taskforce/ National Human Trafficking Unit	Police Scotland
Robin Jamieson	Lead Forensic Physician	NHS Ayrshire & Arran, NHS Lanarkshire, and NHS Greater Glasgow and Clyde
Saira Kapasi	Violence Against Women Justice Lead	Scottish Government
George Laird	Manager	West of Scotland Sexual Health Managed Clinical Network and Child Protection Managed Clinical Network
Jamie Lipton	Principal Procurator Fiscal Depute	Fiscal Service
Colin MacDonald	Service Manager, Police Custody Health Care	NHS Greater Glasgow and Clyde
Jane MacDonell	Consultant Paediatrician	NHS Borders
Rhoda MacLeod	Head of Adult Services (Sexual Health)	Glasgow City Health and Social Care Partnership

Name	Position	Organisation
Tansy Main	Head of Chief Medical Officer's Rape and Sexual Assault Taskforce Unit	Scottish Government
Jan McClean	Regional Healthcare Planner	Regional Collaboratives, South East Scotland
Kate McKay	Chair of Specialist Paediatric Forensic Service Delivery Subgroup	Scottish Government
Graham Milne (Interim only)	Network Programme Manager – Equally Safe Project	NHS National Services Scotland
Barry Muirhead (Interim only)	Clinical Nurse Manager People in Police Care	NHS Lothian
Carol Rogers	Lead Forensic Scientist – Sexual Offence	Scottish Police Authority
Grant Scott	Professional Nurse Advisor	Prison Healthcare Services and Glasgow City Health and Social Care Partnership
Karan Simson	Clinical Team Leader (Police Custody)	NHS Greater Glasgow and Clyde
Shona Stewart (Interim only)	Police Inspector, NHS Liaison, Custody Healthcare & Forensic Medical Services	Police Scotland
Sarah Tait	Manager, East Region Child Protection Managed Clinical Network	NHS Fife
Melanie Wade (Interim only)	Detective Inspector, Public Protection Support, HMICS-Forensic Service Provision	Police Scotland
Deb Wardle	Lead Consultant in Genitourinary Medicine & Sexual Health	Archway, and NHS Greater Glasgow and Clyde
David Wearden (Interim only)	Clinical Lead for Forensic Medicine	NHS Grampian and NHS Highland

The standards development group was supported by the following members of Healthcare Improvement Scotland's Standards and Indicators Team:

- Paula O'Brien – Administrative Officer
- Rachel Hewitt – Project Officer
- Fiona Wardell – Team Lead

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