Meeting:	**NoS Child Protection Clinical Sub Group**
Date:	**20th September 2016**
Item:	**16-16**

DRAFT – Standards of Service Provision and Quality Indicators for the Paediatric Medical Component of Child Protection Services in Scotland

1. Introduction

Purpose

These standards, drawn from current guidance, good practice documents, medical expertise and experience, are intended to improve the quality of the medical component of child protection services. The quality indicators provide a set of evidence informed indicators that can demonstrate, over a period of time, the improvement in quality.

Outcome

Children and young people access high quality, timely and sensitive child protection medical services that meet their needs wherever they are in Scotland.

Scope

The standards and quality indicators apply to:

- NHS Board child protection services that deliver the interface between Health, Police and Social Services in order for medical assessment examinations to be carried out;
- NHS Board medical staff that provide immediate advice and subsequent medical assessment, if necessary, for children and young people where there are child protection concerns.

The standards and quality indicators have been agreed by consultation with the three Regional Managed Clinical Networks for Child Protection (MCNs) which cover Scotland, the Royal College of Paediatricians and Child Health (RCPCH) and the Scottish Government but should not constrain Health Boards to supplement indicators to reflect specific organisational or local priorities.

2. Background

The Scottish Government's Children and Young People's Health Support Group undertook an audit of Health Boards in February 2013 to ascertain the medical workforce situation within Specialist Child Protection Services in Scotland. The responses indicated low numbers of specialist paediatricians for Child Protection services and resultant gaps in the provision of local and regional (MCN) services. It issued its findings to NHS Board Chief Executives and invited discussion with key professionals within the services, regional managers and interested clinicians to scope possible solutions.

The Child and Maternal Health Division of the Scottish Government hosted two engagement events in April and August 2014 where attendees included the regional MCN managers and lead clinicians, senior clinicians and service managers from NHS Boards and a representative from the RCPCH. A subsequent national action plan was agreed which identified six key issues: setting and monitoring standards; data; providing support for complex cases; consistency of provision; systems and processes needed to support consistency and training and developing the workforce. The action plan was to be monitored

by the Children and Young People's Health Support Group based on reports from the Children and Maternal Health Branch of the Scottish Government.

3. Standards

The first set of actions in the national plan is to establish a set of standards and quality indicators for the medical component of child protection services. The Scottish Government consequently hosted a series of meetings beginning in June 2015 which brought together the MCN Managers, lead MCN clinicians and a representative from RCPCH to begin discussions and scoping of the standards.

Taking into account the three quality ambitions of NHS Scotland (safe, person-centred and effective[1]) the standards follow the child or young person's care pathway but with the added layer of responsibility of the service to meet forensic and legal requirements. As mentioned the standards have been drawn from current guidance, good practice documents, medical expertise and experience and each standard is followed by the source of the documentation. It is intended that NHS Boards work towards the implementation of the standards over a period of time.

Standard 1

All children and young people, children's social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least Level 3 safeguarding competencies[2]) available to provide immediate advice and subsequent assessment, if necessary, for children and young people under 16 years of age where there are child protection concerns. This should be extended to 18 years of age in specific circumstances e.g. known to paediatrics with additional needs / vulnerability factors. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported with a written report.

RCPCH 2011 *Facing the Future*, *Standards for Paediatric Services, Standard 10*
Scottish Government 2014 *National Guidance for Child Protection in Scotland*
Scottish Government 2013 *Child Protection Guidance for Health Professionals*
RCPCH 2013 *Child Protection Companion*

Standard 2

In response to notification of concerns that relate to child protection, an Initial Referral Discussion (IRD) should take place between key agencies. Within the IRD, agencies will consider further information to inform the decision to initiate a child protection investigation and to explore the need for a medical examination. The paediatrician will be responsible in deciding if a medical assessment is required and will agree with police and social work colleagues the nature, timing and venue for the examination.

Scottish Government 2014 *National Guidance for Child Protection in Scotland*
Scottish Government 2013 *Child Protection Guidance for Health Professionals*

[1] The Scottish Government, 'NHS Scotland Quality Strategy', 2010

[2] Safeguarding competencies as defined in Safeguarding Children and Young People: roles and responsibilities, Intercollegiate Document March 2014

Police Scotland and NHS Scotland 2013 ***National Guidance on the Delivery of Police Custody Healthcare and Forensic Medical Services***
FFLM & RCPCH 2015 ***Service specification for the clinical evaluation of children and young people who may have been sexually abused***

Standard 3

A Joint Paediatric Forensic (JPF) examination is usually conducted by a paediatrician and a forensic physician. The JPF examination combines a comprehensive medical assessment with the need for corroboration of forensic findings and the taking of appropriate photographs of injuries or specimens, If two professionals, or more, are involved they need to determine in advance of the assessment what skills they bring to the examination and who will undertake which component of the examination. It may be necessary to involve another complementary medical professional such as a genitourinary physician, orthopaedic surgeon, or family planning doctor, if the case demands it.

Scottish Government 2014 ***National Guidance for Child Protection in Scotland***
Scottish Government 2013 ***Child Protection Guidance for Health Professionals***
Police Scotland and NHS Scotland 2013 ***National Guidance on the Delivery of Police Custody Healthcare and Forensic Medical Services***

Standard 4

If there are multi health professional specialists involved in a complex case[3], a round table discussion is required after assessments are completed. The identified Lead Clinician for the case should produce a summary of the discussion which clearly documents areas of agreement and disagreement.

RCPCH 2013 ***Child Protection Companion***

Standard 5

All child protection examinations, including examinations of underage suspected perpetrators, must take place in a suitably age appropriate space with a waiting area, appropriate toys and distraction for the examination and have appropriate clinical facilities. Age appropriate information resources should be available for children undergoing examination.

RCPCH 2013 ***Child Protection Companion***
FFLM & RCPCH 2015 ***Service specification for the clinical evaluation of children and young people who may have been sexually abused***

Standard 6

For Joint Paediatric Forensic (JPF) examinations involving sexual abuse/assault cases, all NHS Boards will ensure standardised cleaning and decontamination policies are adopted. This should be done as agreed by each NHS Board and Police Scotland, but should take into account nationally agreed procedures and standards along with any recommendations from the Scottish Police Authority (SPA) Forensic Service

[3] Complex cases as described in the three Regional Child Protection MCNs, *Terms of Reference for the Inter-Regional Child Protection Forum on Complex Cases, April 2015*

FFLM 2012 ***Operational procedures and equipment for medical facilities in victim examination suites or Sexual Assault Referral Centres (SARCs*****)**
Police Scotland and NHS Scotland 2013 ***National Guidance on the Delivery of Police Custody Healthcare and Forensic Medical Services,***
FFLM & RCPCH 2015 ***Service specification for the clinical evaluation of children and young people who may have been sexually abused***

Standard 7

For Joint Paediatric Forensic (JPF) examinations involving sexual abuse/assault NHS Boards should provide access to both a competently trained paediatrician and forensic physician who can carry out timely examinations with a colposcope or equivalent, including photodocumentation*.

RCPCH 2015 ***The Physical Signs of Child Sexual Abuse***
Police Scotland and NHS Scotland 2013 ***National Guidance on the Delivery of Police Custody Healthcare and Forensic Medical Services***
FFLM & RCPCH 2012 ***Guidelines on Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse***
FFLM & RCPCH 2015 ***Service specification for the clinical evaluation of children and young people who may have been sexually abused***

* Sexual assault referral centres (SARCs) may assess 13-16 year olds where there has been an acute assault.

Standard 8

Discussion with a specialist paediatrician and forensic physician about cases of acute sexual assault should be available within 4 hours of the case being referred to the NHS Board. The timing of an examination will be determined by the examining doctor(s) after discussion with appropriate parties based on the clinical and forensic needs of the case and in the best interests of the child.

RCPCH 2015 ***The Physical Signs of Child Sexual Abuse***

Standard 9

As part of any child protection examination there should be consideration of the ongoing health care, monitoring and treatment that the child may require. This should address any unmet health needs and appropriate onward referral to specialists, including consideration of access to the screening and treatment of sexually transmitted infections, risk assessment for post-exposure prophylaxis, emergency contraception and pregnancy testing, mental health services and therapeutic support for the child and family.

Scottish Government 2014 ***National Guidance for Child Protection in Scotland*****; RCPCH 2015** ***The Physical Signs of Child Sexual Abuse***
FFLM & RCPCH 2015 ***Service specification for the clinical evaluation of children and young people who may have been sexually abused***

Standard 10

Consent from the appropriate person with parental responsibility, or the child if appropriate, must be obtained in writing by the examining doctor(s) before the examination takes place. The examining doctor(s) must ensure adequate information about the procedure, and how the results may be used, is provided to children and their families in order that properly informed consent is given.

Scottish Government 2014 *National Guidance for Child Protection in Scotland*

Standard 11

All examining doctor(s) must make comprehensive contemporaneous notes using standardised documentation to cover the components of the examination that they are responsible for (as agreed prior to the assessment).

RCPCH 2013 *Child Protection Companion*

FFLM & RCPCH 2012 *Guidelines on Paediatric Forensic Examinations in Relation to Possible Child Sexual Abuse*

Standard 12

After a child protection examination a report, the contents of which is outlined in the *Child Protection Guidance for Health Professionals*[4], should be provided by the examining doctor. For Joint Paediatric Forensic (JPF) examinations there should be a joint interim report at the time of examination with a more detailed joint report available within 3-4 weeks. Less experienced doctors should have their reports checked by their supervising consultant or a more experienced colleague.

RCPCH 2013 *Child Protection Companion*

Scottish Government 2013 *Child Protection Guidance for Health Professionals*

RCPCH 2015 *The Physical Signs of Child Sexual Abuse*

FFLM & RCPCH 2015 *Service specification for the clinical evaluation of children and young people who may have been sexually abused*

Standard 13

Agreed data sets for the service provision of the paediatric medical component of child protection services should be collected and reported across each MCN region in order to capture standardised information on activity and performance against quality indicators.

FFLM & RCPCH 2015 *Service specification for the clinical evaluation of children and young people who may have been sexually abused*

Standard 14

Provision of the paediatric medical component of child protection services and timely access to expert child protection advice is best provided through a managed clinical network arrangement.

FFLM & RCPCH 2015 *Service specification for the clinical evaluation of children and young people who may have been sexually abused*

4. Indicators

One of the core principles of Managed Clinical Networks is to facilitate continuous quality improvement and audit based on a documented evidence base[5]. Consequently the quality indicators were developed by the three MCNs in order to demonstrate that the standards are being worked towards and quality improvement occurring.

[4] Scottish Government, 'Child Protection Guidance for Health Professionals', 2013

[5] The Scottish Government, 'Managed Clinical Networks: Supporting and Delivering The Healthcare Quality Strategy', CEL 29(2012)

The indicators are intended to promote understanding and comparison, focusing on quality improvement rather than measure of performance. Therefore no performance thresholds have been incorporated. It is envisioned that those delivering the service can interrogate the data to answer questions about service delivery and consequently drive forward the quality of care delivered.

All of the indicators in this Framework follow the same format:

- **Indicator** – what we are trying to achieve
- **Supporting literature** – the reason this indicator is considered important. The information has been extracted from NHS standards and clinical guidelines, The majority are direct quotations and corresponding references can be found in the foot notes at the bottom of each page,
- **Operational Definition** – how information is collected to demonstrate progress measurement against the indicator
    - **Numerator** - number of episodes where people experienced the outcome of interest
    - **Denominator** - number of episodes where people could potentially have experienced that outcome
- **Exclusions** – what is not included for measurement
- **Data source** – where to obtain data for measurement

It is recognised that NHS Boards and MCNs may not have the infrastructures in place at this time to collect the information on a continuous basis to demonstrate progress against the indicators. Consequently the three regional MCNs will work with their respective NHS Boards to advice on systems and processes that this can happen over a period of time. Audit for an agreed period can be instigated in the meantime to show progress.

It is the intention that the three regional MCNs will draw together their respective NHS Board data sets on a regular basis to work collaboratively on quality improvements. The data will also be combined to reflect a national picture for regional planning group forums and to highlight areas where national collaboration will enable a more effective quality improvement programme.

5. Summary of Indicators

A summary of the indicators is shown below with the full description of the indicators following:

Measure No.	Indicator	Page No.
1	A paediatrician with child protection experience and skills (of at least Level 3 safeguarding competencies) is available at all times to provide immediate advice and subsequent assessment, if necessary, for children and young people where there are child protection concerns.	
2	% of episodes where children have an Interagency Referral Discussion (IRD) before a Joint Paediatric Forensic (JPF) examination is carried out.	
3	% of episodes where it has been agreed that a Joint Paediatric Forensic examination should take place and subsequently the examinations involves at least a Paediatrician and a Forensic Physician.	
4	Facilities used for child protection examinations, including for under age suspected perpetrators, are age appropriate.	
5	Cleaning and decontamination policies are in place, that take into account nationally agreed procedures and standards, to ensure. Joint Paediatric Forensic (JPF) examinations involving sexual abuse/assault cases are carried out in appropriate facilities.	
6	Joint Paediatric Forensic (JPF) examinations involving sexual abuse/assault cases include both a competently trained paediatrician and forensic physician who can carry out timely examinations with a colposcope or equivalent, including photodocumentation.	
7	% of cases of acute sexual assault where a discussion with a specialist paediatrician and forensic physician occurred within 4 hours of the case being referred to the NHS Board.	
8	% of episodes where examining doctors make comprehensive contemporaneous notes using standardised documentation during child protection examinations.	
9	% of episodes where a detailed joint report, produced by the examining Paediatrician and Forensic Physician, is available within 3-4 weeks following Joint Paediatric Forensic (JPF) examinations.	

Quality Indicators

Measure 1	A paediatrician with child protection experience and skills (of at least Level 3 safeguarding competencies) is available at all times to provide immediate advice and subsequent assessment, if necessary, for children and young people where there are child protection concerns.
Rationale	All children and young people, children's social care, police and health teams have access to a paediatrician with child protection experience and skills (of at least Level 3 safeguarding competencies[6]) available to provide immediate advice and subsequent assessment, if necessary, for children and young people under 16 years of age where there are child protection concerns. This should be extended to 18 years of age in specific circumstances e.g. known to paediatrics with additional needs / vulnerability factors. The requirement is for advice, clinical assessment and the timely provision of an appropriate medical opinion, supported with a written report.[7],[8]
Definition	Describe how this measure is provided for by the Health Board and if there any exceptions or gaps in service (quantify this in hours). *Children* is defined as up to the age of 16 – the child's 16th birthday[9].
Exclusions	None
Data source	Annual statement from the Health Board Child Protection Lead Specialist

[6] Intercollegiate Document (March 2014) *Safeguarding Children and Young People: roles and responsibilities*

[7] Regional MCNs (2016) *Standards of service provision for the paediatric medical component of child protection service in Scotland, Standard 1*

[8] RCPCH (2011) *Facing the Future, Standards for Paediatric Services: Standard 10*

[9] "The CSA service will ideally see children up to their eighteenth birthday, but definitely children up to their sixteenth birthday" Royal College of Paediatrics and Child Health and Faculty of Forensic and Legal Medicine (2015) *Service Specification for the clinical evaluation of children and young people who may have been sexually abused &* "The Paediatric Forensic Medical Services Group agreed, with the support of the South East and North of Scotland, that paediatric examinations should definitely cover the age of 16 years and up to age 18 for those who were considered vulnerable (i.e lacking capacity, looked after children, children within the reporting system), however, it was acknowledged that this would cause practical difficulties." *Minute of meeting 12th May 2015*

Measure 2	% of episodes where children have an Interagency Referral Discussion (IRD) before a Joint Paediatric Forensic (JPF) examination is carried out.
Rationale	Initial / Interagency referral discussions (IRD), or equivalent, must always take place following child protection referrals to police, social work or health professionals. The IRD allows sharing of information and decisions to be made primarily on the needs and safety of the child. The paediatrician involved in the IRD makes the decision around the requirement of a medical assessment, agreeing with police and social work colleagues the nature, timing and venue for examination[10]. Interagency referral discussions must always take place in child protection referrals to police, social work or health professionals. The IRD allows decisions to be made primarily based on the needs and safety of the child and reduces differences in expectation between police and health services on the timing of examination and collection of forensic evidence[11]. It is essential that a multi-agency discussion takes place. This may be face to face or via telephone[12].
Definition	Numerator: number of JPF examinations where an interagency referral discussion involving police, social work and health professionals has taken place previously. Denominator: number of JPF examinations *Children* is defined as up to the age of 16 – the child's 16th birthday[13]. *Interagency Referral Discussion* is defined in local NHS Board, Local Authority and Police Scotland joint protocols / guidelines
Exclusions	None
Data source	Annual audit of case records by the Health Board child protection team

[10] Regional MCNs (2016) *Standards of service provision for the paediatric medical component of child protection service in Scotland, Standard 2*
[11] Scottish Government (2012) *Forensic Paediatrics: a Report by the Short Life Working Group*,
[12] Royal College of Paediatrics and Child Health and Faculty of Forensic and Legal Medicine (2015) *Service Specification for the clinical evaluation of children and young people who may have been sexually abused*
[13] "The CSA service will ideally see children up to their eighteenth birthday, but definitely children up to their sixteenth birthday" Royal College of Paediatrics and Child Health and Faculty of Forensic and Legal Medicine (2015) *Service Specification for the clinical evaluation of children and young people who may have been sexually abused & "*The Paediatric Forensic Medical Services Group agreed, with the support of the South East and North of Scotland, that paediatric examinations should definitely cover the age of 16 years and up to age 18 for those who were considered vulnerable (i.e lacking capacity, looked after children, children within the reporting system), however, it was acknowledged that this would cause practical difficulties." *Minute of meeting 12th May 2015*

Measure 3	% of episodes where it has been agreed that a Joint Paediatric Forensic examination should take place and subsequently the examinations involves at least a Paediatrician and a Forensic Physician.
Supporting literature	A Joint Paediatric Forensic (JPF) examination is usually conducted by a paediatrician and a forensic physician. The JPF examination combines a comprehensive medical assessment with the need for corroboration of forensic findings and the taking of appropriate photographs of injuries or specimens. If two professionals, or more, are involved they need to determine in advance of the assessment what skills they bring to the examination and who will undertake which component of the examination. It may be necessary to involve another complimentary medical professional such as a genitourinary physician, orthopaedic surgeon, or family planning doctor, if the case demands it. [14] For child sexual abuse examinations, all NHS Boards will provide access to a competently trained paediatrician and forensic physician who can carry out timely examinations with a colposcope or equivalent, including photodocumentation.[15] The presence of two doctors in the joint paediatric forensic examination is important for the corroboration of medical evidence in any subsequent criminal proceeding and is also good medical practice. [16] This two doctor examination is the most specialised type of examination ……..It is usually carried out by a paediatrician and forensic physician, but can be carried out by paediatric and any other appropriately trained doctor.[17]
Operational definition	Numerator: number of episodes where it has been agreed that a Joint Paediatric Forensic examination for child protection matters have at least a two doctor examination involving a Paediatrician and a Forensic Physician Denominator: number of episodes where children are referred for a Joint Paediatric Forensic examination for assessment of potential child abuse
Exclusions	Sexual Assault Referral Centres (SARCs) may examine 13-16 year olds where there has been an acute assault. JPF examinations where consent was not obtained for the examination.
Data source	Annual audit of case records by the Health Board child protection team

[14] Regional MCNs (2016) *Standards of service provision for the paediatric medical component of child protection service in Scotland, Standard 3;*

[15] Regional MCNs (2016) *Standards of service provision for the paediatric clinical component of child abuse services, Standard 6;*

[16] Scottish Government (2014) *National Guidance for Child Protection in Scotland;*

[17] Scottish Government (2013) *Child Protection Guidance for Health Professionals*; National Coordinating Network for Healthcare and Forensic Medical Services for People in Police Care (2015) *National Guidance on the Delivery of Police Custody Healthcare and Forensic Medical Services.*

Measure 4	Facilities used for child protection examinations, including for under age suspected perpetrators, are age appropriate.
Supporting literature	All child protection examinations, including examinations of underage suspected perpetrators, must take place in a suitably age appropriate space with a waiting area, appropriate toys and distraction for the examination and have appropriate clinical facilities[18]. The central hub must be designed to meet the demands of the forensic collection…….as well as providing a child friendly environment[19].
Operational definition	Describe how this measure is provided for by the Health Board and if there any exceptions or gaps in provision.
Exclusions	None
Data source	Annual statement from the Health Board Child Protection Lead Specialist

[18] Regional MCNs (2016) *Standards of service provision for the paediatric medical component of child protection service in Scotland, Standard 5;* RCPCH (203) *Child Protection Companion;*
[19] FFLM & RCPCH (2015) *Service specification for the clinical evaluation of children and young people who may have been sexually abused*

Measure 5	Cleaning and decontamination policies are in place, that take into account nationally agreed procedures and standards, to ensure Joint Paediatric Forensic (JPF) examinations involving sexual abuse/assault cases are carried out in appropriate facilities.
Supporting literature	For Joint Paediatric Forensic (JPF) examinations involving sexual abuse/assault cases, all NHS Boards will ensure standardised cleaning and decontamination policies are adopted. This should be done as agreed by each NHS Board and Police Scotland, but should take into account nationally agreed procedures and standards along with any recommendations from the Scottish Police Authority (SPA) Forensic Service[20] The room or suite needs to be cleaned before each use to minimise the potential for contamination. This should be done as agreed by each Health Board and Police Scotland, but should take into account nationally agreed procedures and standards along with any recommendations from the Scottish Police Authority (SPA) Forensic Service[21] The central hub must be designed to meet the demands of the forensic collection i.e. capable of being forensically cleaned and capable of storing forensic samples [22] Operational procedures and equipment for medical facilities in victim examination suites or Sexual Assault Referral Centres (SARCs)[23]
Operational definition	Confirm policies in place.
Exclusions	None
Data source	Annual statement from the Health Board child protection lead specialist.

[20] Regional MCNs (2016) *Standards of service provision for the paediatric medical component of child protection service in Scotland, Standard 5;*

[21] National Coordinating Network for Healthcare and Forensic Medical Services for People in Police Care (2015) *National Guidance on the Delivery of Police Custody Healthcare and Forensic Medical Services*

[22] FFLM & RCPCH (2015) *Service specification for the clinical evaluation of children and young people who may have been sexually abused*

[23] FFLM (2012) *Operational procedures and equipment for medical facilities in victim examination suites or Sexual Assault Referral Centres (SARCs*)

Measure 6	Joint Paediatric Forensic (JPF) examinations involving sexual abuse/assault cases include both a competently trained paediatrician and forensic physician who can carry out timely examinations with a colposcope or equivalent, including photodocumentation.
Rationale	For Joint Paediatric Forensic (JPF) examinations involving sexual abuse/assault NHS Boards should provide access to both a competently trained paediatrician and forensic physician who can carry out timely examinations with a colposcope or equivalent, including photodocumentation.[24] Forensic evidence collection should include colposcope examination[25]. The DVD recording from video colposcopy provides the best quality of forensic evidence in relation to intimate examinations and enables the Crown to obtain, where necessary, the opinion of a medical expert not present at the examination. It also affords any defence medical experts an opportunity to view the recording and prevents need for repeated examinations[26]. As in all forms of abuse, high quality photo documentation and video-documentation, using appropriate equipment is an essential part of the documentation of physical signs of sexual abuse where consent is giving[27].
Definition	Describe how this measure is provided for by the Health Board and if there any exceptions or gaps in provision.
Exclusions	JPF examinations where consent was not obtained for the examination.
Data source	Annual statement from the Health Board child protection lead specialist.

[24] Regional MCNs (2016) *Standards of service provision for the paediatric medical component of child protection service in Scotland, Standard 7;*
[25] European Parliament (2013)
[26] National Coordinating Network for Healthcare and Forensic Medical Services for People in Police Care (2015) *National Guidance for the delivery of healthcare and forensic medical services for people in police care*
[27] FFLM & RCPCH (2015) *Service specification for the clinical evaluation of children and young people who may have been sexually abused*

Measure 7	% of cases of acute sexual assault where a discussion with a specialist paediatrician and forensic physician occurred within 4 hours of the case being referred to the NHS Board.
Rationale	Discussion with a specialist paediatrician and forensic physician about cases of acute sexual assault should be available within 4 hours of the case being referred to the NHS Board. The timing of an examination will be determined by the examining doctor(s) after discussion with appropriate parties based on the clinical and forensic needs of the case and in the best interests of the child[28].
Definition	Numerator: number of cases of acute sexual assault where a discussion between the Police or social care with a specialist paediatrician and forensic physician occurred within 4 hours of the case being referred to the NHS Board. Denominator: number of referrals of acute sexual assault.
Exclusions	None
Data source	Annual audit of case records by the Health Board child protection team

[28] Regional MCNs (2016) *Standards of service provision for the paediatric medical component of child protection service in Scotland, Standard 8;*

Measure 8	% of episodes where examining doctors make comprehensive contemporaneous notes using standardised documentation during child protection examinations.
Rationale	All examining doctor(s) must make comprehensive contemporaneous notes using standardised documentation to cover the components of the examination that they are responsible for (as agreed prior to the assessment).[29] [30] An appropriate standard of documentation, using a specifically designed standard medical proforma.[31]
Definition	Numerator: number of episodes where examining doctors make comprehensive contemporaneous notes using standardised documentation during child protection examinations. Denominator: number of child protection examinations
Exclusions	Child protection examinations where consent was not obtained for the examination
Data source	Annual audit of case records by the Health Board child protection team

[29] Regional MCNs (2016) *Standards of service provision for the paediatric medical component of child protection service in Scotland, Standard 11;*
[30] RCPCH (2015) *The Physical Signs of Child Sexual Abuse* & RCPCH and FFLM (2015) *Service specification for the clinical evaluation of children and young people who may have been sexually abused*
[31] FFLM & RCPCH (2015) *Service specification for the clinical evaluation of children and young people who may have been sexually abused*

Measure 9	% of episodes where a detailed joint report, produced by the examining Paediatrician and Forensic Physician, is available within 3-4 weeks following Joint Paediatric Forensic (JPF) examinations.
Rationale	After a child protection examination a report, the contents of which is outlined in the Child Protection Guidance for Health Professionals 2013, should be provided by the examining doctor. For Joint Paediatric Forensic (JPF) examinations there should be a joint interim report at the time of examination with a more detailed joint report available within 3-4 weeks. Less experienced doctors should have their reports checked by their supervising consultant or a more experienced colleague.[32] Both medical specialists (Paediatrician and Forensic Physician) are responsible for the forensic interpretation of the clinical findings noted, and the provision of appropriate, detailed and structured formal reports to the relevant agencies including health, social work and police.[33]
Definition	Numerator: number of episodes where a joint report is produced within 3-4 weeks of the Joint Paediatric Forensic (JPF) examination. Denominator: number of Joint Paediatric Forensic (JPF) examinations
Exclusions	None
Data source	Annual audit of case records by the Health Board child protection team

[32] Regional MCNs (2016) *Standards of service provision for the paediatric medical component of child protection service in Scotland, Standard 12;*

[33] National Coordinating Network for Healthcare and Forensic Medical Services for People in Police Care (2015) *National Guidance for the delivery of healthcare and forensic medical services for people in police care*